

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03227 | | | |
|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-30-81 | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Ossie M. ADAMS | | | | 2b. HOUR 12:25P M | | | |
| 3. SEX F | | 4. RACE B | | 5. DATE OF BIRTH MONTH DAY YEAR 8-1-00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Farrington | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha Waters | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Flora Farrington Port Noyce, N.J. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) 4292 Night CVA DUE TO, OR AS A CONSEQUENCE OF (b) ASCVD DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost } years | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) prev. left CVA & right hemiparesis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph C. Fitzgerald M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/30/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. JOSEPH C. FITZGERALD, M.D. | | | | 22e. ADDRESS CIVIC AVE. & RT 50, SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2-3-1981 | | 23c. NAME OF CEMETERY OR CREMATORY GREEN ACRES | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md. | |
| 24. FUNERAL DIRECTOR NAME Clinton F. Stewart ADDRESS West Rd + Olviast. | | | | 25a. DATE REC'D BY REGISTRAR FEB 4 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS ANTICIPATED, THE EXAMINER SHOULD WRITE "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 4. THIS IS A BUREAU-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH-17
(VR A15 ME (5))
15M 7/76

FOR
1- STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

03228

| | | | | | | | |
|---|---------|--|-------------------|---|----------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE KNOWN OF DEATH | | 2b. HOUR |
| Albert E. Alford, Sr. | | | | | DATE KNOWN OF DEATH | 1 17 81 | 1135 P M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE (IN YEARS) | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | 9. HOUR |
| Male | White | 9 17 25 | 55 YRS. | | | 1 17 81 | 1135 P M |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MARYLAND | | U.S.A. | | | | Wilcomico MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | Peninsula San'l Hosp | | POLICEMAN | | CITY | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Md | | Worcester | | Ocean City | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 16a. SOCIAL SECURITY NO. | | 17. INFORMANT | |
| WILLIAM S. ALFORD | | HARRIET V. COANTHWAITE | | 213-20-8785 | | Mrs. Jacqueline D. Alford - 110 Sea Lane | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| YES | | KOREAN | | Mrs. Jacqueline D. Alford - 110 Sea Lane | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Chronic Obstructive lung Disease</u> 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) | | DATE SIGNED | | | |
| Earl L. Roper | | Deputy | | 1-18-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S | |
| Earl L. Roper | | 409 Camden Ave Salisbury Md | | JAN 21 1981 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| BURIAL | | 1-22-81 | | PARK WOOD CEM. | | BALTO. MD. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S | |
| Hartley-Miller | | 7527 HARFORD RD | | JAN 21 1981 | | | |

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[Handwritten signature]

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE MEDICAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 IN YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED IN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03229 | |
|---|---------|--|---------|--|---------------------|---|--|---|--|---------------------------------------|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| | | WILLIAM ALFRED ANDERSON | | | | | | ESTIMATED 1-29-81 | | 5:30 P.M. | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | 6. AGE | 7. IF UNDER 1 YR. | 8. IF UNDER 24 HRS. | 9. DATE PRONOUNCED DEAD | | 10. MONTH | | 11. DAY | |
| Male | White | 2 27 1896 | 84 YRS. | | | 1-29-81 | | 19 | | 5:45 P.M. | |
| 12. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 13. CITIZEN OF WHAT COUNTRY? | | 14. MARRIED | | 15. NEVER MARRIED | | 16. DIVORCED | | 17. BALTIMORE CITY OR COUNTY OF DEATH | |
| N.Y. City | | U.S. | | WIDOWED | | NEVER MARRIED | | DIVORCED | | Wicomico MD. | |
| 18. CITY OR TOWN OF DEATH | | 19. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | | | 20. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING YRS.) | | 21. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | #38 Hancock Trailer Park | | | | Ret. Police Officer | | Officer | | | |
| 22. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 23. STATE | | 24. CITY OR TOWN | | 25. INSIDE CITY LIMITS? | | 26. STREET ADDRESS | | | |
| Md. | | Wicomico | | Salisbury | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | #38 Hancock Trailer Park | | | |
| 27. FATHER'S NAME | | 28. MOTHER'S MAIDEN NAME | | 29. SOCIAL SECURITY NO. | | 30. INF. OF DEATH | | 31. ADDRESS | | | |
| Unknown | | Unknown | | 162-30-8657 | | George Anderson | | Philadelphia, Pa. | | | |
| 32. WAS DECEASED EVER IN U.S. ARMED FORCES? | | 33. SOCIAL SECURITY NO. | | 34. INF. OF DEATH | | 35. ADDRESS | | 36. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| No | | 162-30-8657 | | George Anderson | | Philadelphia, Pa. | | sudden | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | | |
| PART I DEATH WAS CAUSED BY: | | | | | | | | | | | |
| IMMEDIATE CAUSE (a) Coronary Occlusion | | | | | | | | | | | |
| 4100 } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. } (b) ASCVD | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | |
| | | HOUR A.M. MONTH DAY YEAR | | (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | (AT HOME, STREET, FACTORY, FARM, ETC.) | | CITY OR TOWN COUNTY STATE | |
| | | P.M. 19 | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural Causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| 23. ACTUAL SIGNATURE | | 24. TITLE (SPECIFY) | | | | | | 25. DATE REC'D. BY REGISTRAR | | 26. REGISTRAR'S SIGNATURE | |
| Earl L. Royer, M.D. | | Deputy | | | | | | FEB 5 1981 | | Baltimore | |
| 27. EXAMINER'S NAME (TYPE OR PRINT) | | 28. ADDRESS | | | | | | 29. CITY OR TOWN | | 30. COUNTY STATE | |
| Earl L. Royer, M.D. | | 1409 Camden Ave., Salisbury, Md. | | | | | | Tyson Cam. | | Tyson Cam. | |
| 31. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 32. DATE | | 33. NAME OF CEMETERY OR CREMATORY | | 34. LOCATION | | 35. CITY OR TOWN | | 36. COUNTY STATE | |
| Burial | | 1/31/81 | | Tyson Cam. | | Tyson Cam. | | Tyson Cam. | | Tyson Cam. | |
| 37. FUNERAL DIRECTOR NAME | | 38. ADDRESS | | 39. DATE REC'D. BY REGISTRAR | | 40. REGISTRAR'S SIGNATURE | | 41. CITY OR TOWN | | 42. COUNTY STATE | |
| Messick Funeral Home, Bivalve, Md. | | | | FEB 5 1981 | | Baltimore | | Baltimore | | Baltimore | |

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1958 FEB 2 832

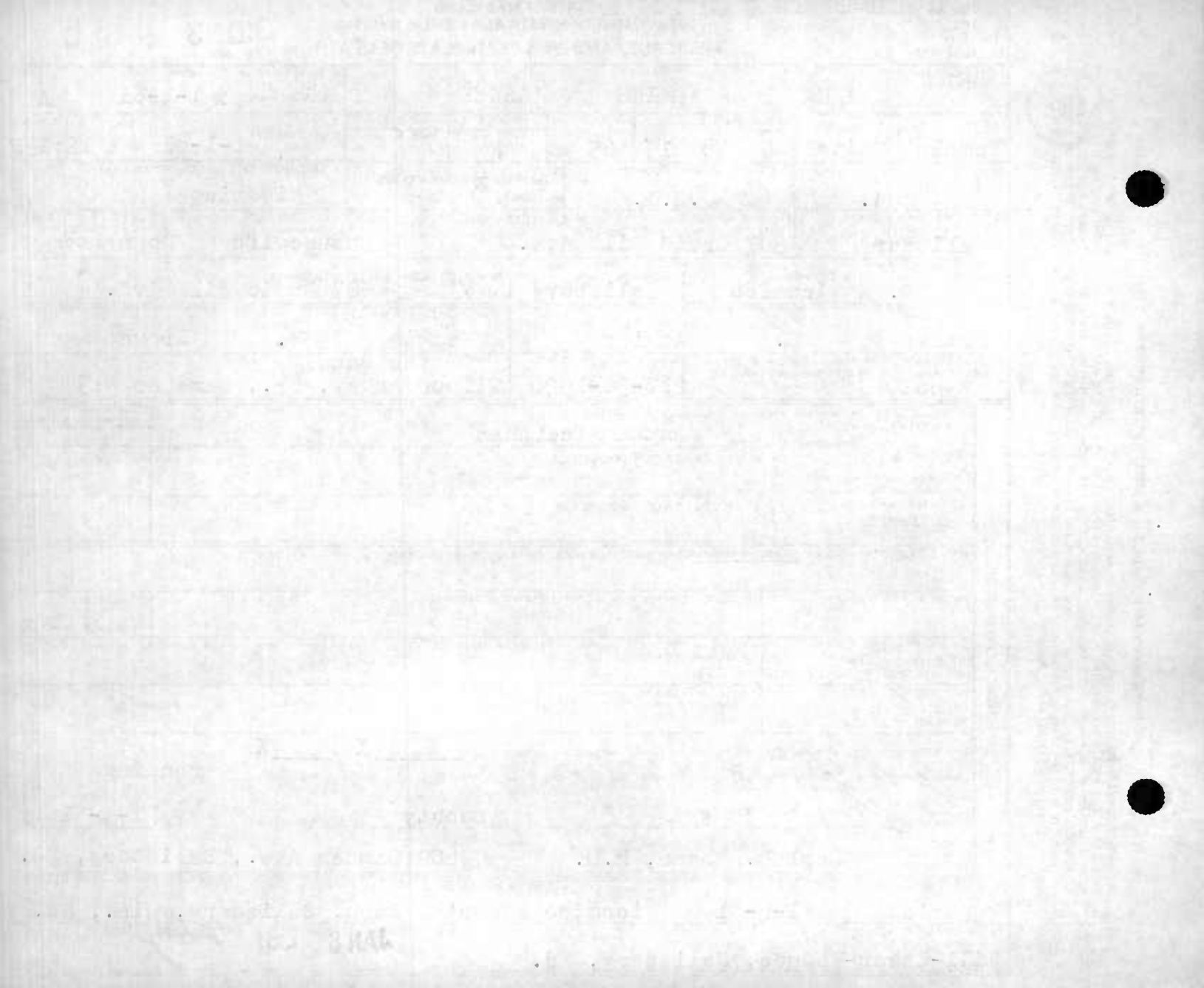
BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| See item 18-22 Film G 5551 1/29/81 STATE OF MARYLAND | | | | | | | | | |
|--|--|---|--|--|--|---|--|--|--|
| DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | |
| MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | |
| REG. NO. 03230 | | | | | | | | | |
| 1- STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST IRMA ADKINS ASKEY | | | | | | | | | |
| 2a. DATE KNOWN OF DEATH | | 2b. HOUR | | 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | |
| ESTIMATED <input checked="" type="checkbox"/> 1-1-81 | | A M | | Female | | White | | 4 18 15 65 YRS. | |
| 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | |
| 1-1-81 | | 12:15P | | MONTHS DAYS HOURS MIN | | Md. | | U.S.A. | |
| 2e. DATE PRONOUNCED DEAD | | 2f. HOUR | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | 10. CITY OR TOWN OF DEATH | |
| 1-1-81 | | 12:15P | | | | Wicomico | | Salisbury | |
| 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | 13a. STATE | | 13b. COUNTY | |
| 507 Druid Hill Ave. | | housewife | | own home | | Md. | | Wicomico | |
| 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | 14. FATHER'S NAME (FIRST MIDDLE LAST) | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) | |
| Salisbury | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 507 Druid Hill Ave. | | Arthur C. Adkins | | Nettie B. Brown | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT (husband) ADDRESS | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| no | | 217-36-1920 | | Wilbur Askey, Sr., same as #13 | | PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion | | | |
| | | | | | | Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | |
| | | | | | | (b) | | | |
| | | | | | | DUE TO, OR AS A CONSEQUENCE OF | | | |
| | | | | | | (c) | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? | | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Pending | | | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 1-5-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | | | 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | |
| Earl L. Royer, M.D. | | 409 Camden Ave., Salisbury, Md. | | | | burial | | | |
| 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN | | COUNTY | | STATE | |
| 1-4-81 | | Wicomico Memorial Park, Salisbury, Wic., Md. | | Salisbury, Wic., Md. | | Wicomico | | Md. | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR SIGNATURE | | | |
| Hill-Baker-Bounds, Salisbury, Md. | | | | JAN 8 1981 | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

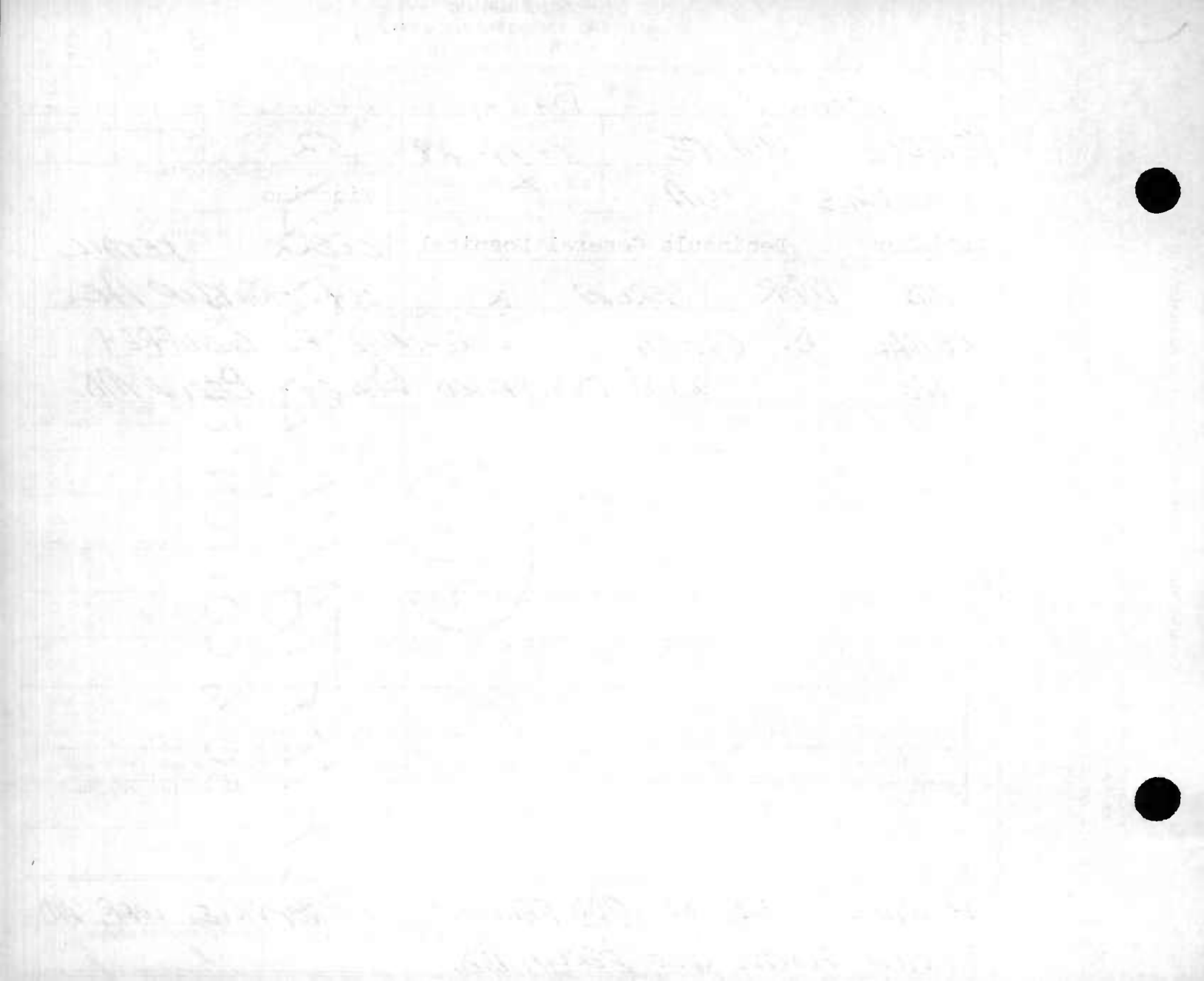
03231

| | | | | | | | | | | |
|--|--|--|---|--|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) MARCIA BOSTON AYDELOTTE | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 31 1981 | | | 2b. HOUR 2:42 M | | | | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR AUG 31, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE MARYLAND | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN SALISBURY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 516 Gordy Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph Boston | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sadie Matthews | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 214-74-6424 | | 17. INFORMANT ADDRESS Naylon Mill Rd. Salisbury, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Bowel obstruction 5609 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 10 days | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Congestive Heart Failure. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (a) this hospital attended the deceased from 1-20 19 81 , to 1-31 19 81 , that (b) (we) lost the deceased alive on 1-30 19 81 , and that in (c) (my) (our) opinion death occurred on the date and hour and from the causes stated above. (a) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Roger C. Merrill MD | | | | | | DEGREE MD | | 22c. DATE SIGNED 1-31-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Roger C. Merrill | | | | | | 22e. ADDRESS KAY AVE Salisbury, Md 21801 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2/3/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem PK | | 23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY Wic MD | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds ADDRESS Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 6 1981 | | 25b. REGISTRAR'S SIGNATURE | | |

BP



| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Bernice C. Bailey | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 24, 1981 | | 2b. HOUR 10 ³⁵ ₄ M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 3-14-28 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CLERK | | 12b. KIND OF BUSINESS OR INDUSTRY RETAIL | |
| 13a. STATE MD | | 13b. COUNTY WOR | | 13c. CITY OR TOWN BERLIN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ERMA D. CLOGG | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST VIRGINIA F. GODFREY | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 213-22-9713 | |
| 17. INFORMANT NAME DENARD BAILEY | | ADDRESS BERLIN, MD. | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cervical Cancer 1809 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from 1/21 , 19 81 , to 1/24 , 19 81 , that (I) (we) lost saw the deceased alive on 1/24 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above; (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Joseph M. Grasso MD | | | | DEGREE MD | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph M. Grasso | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE OR PRINT) BURIAL | | 23b. DATE 1-26-81 | | 23c. NAME OF CEMETERY OR CREMATORY ODD FELLOWS | | 23d. LOCATION CITY OR TOWN COUNTY STATE BISHPURVILLE, WOR, MD. | |
| 24. FUNERAL DIRECTOR NAME ULLRICH FUNERAL HOME | | | | ADDRESS BERLIN, MD. | | 25. FILED BY FEB 2 1981 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers: Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

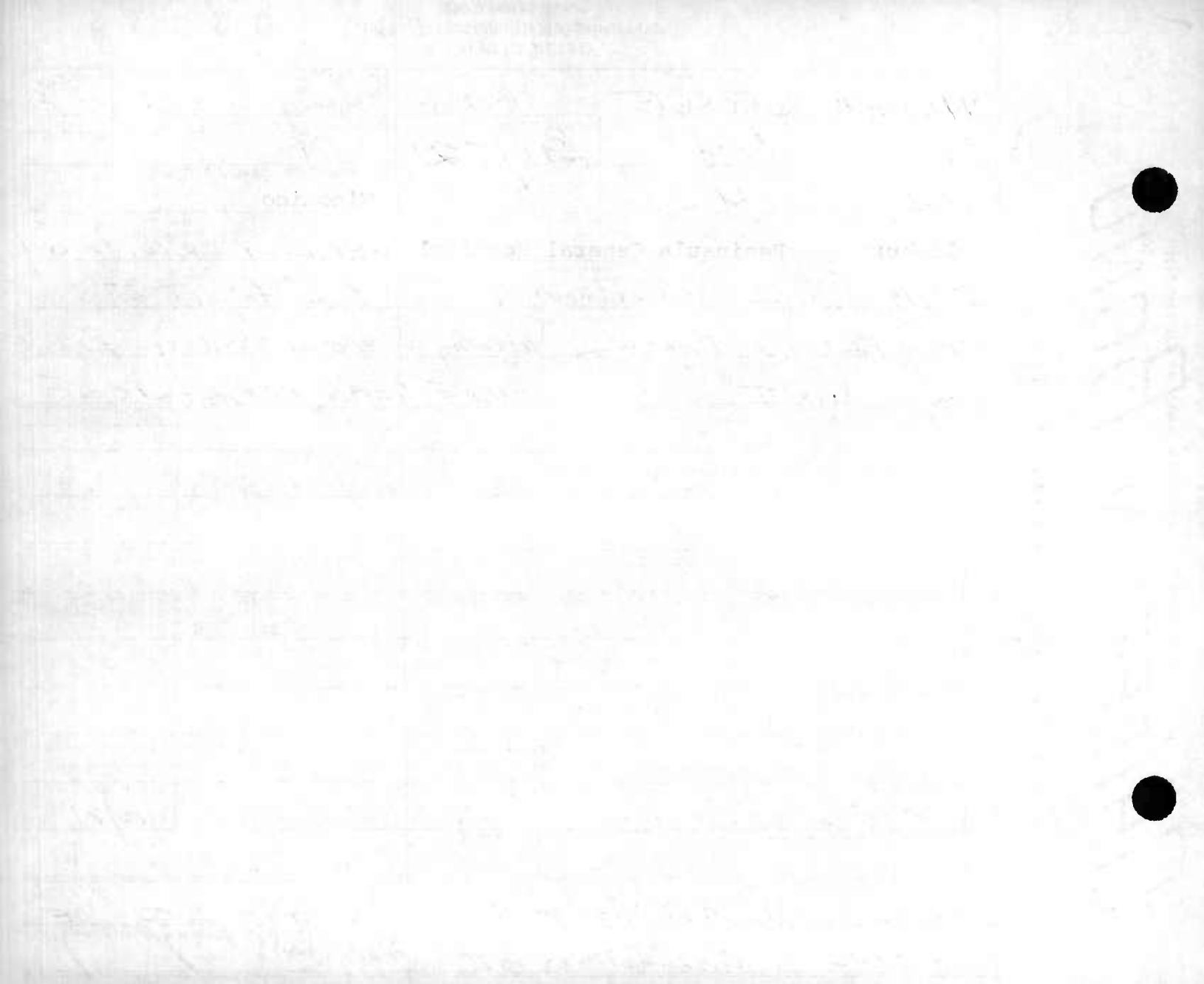
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 3 2 3 3

1. FOR
STATE
REGISTRAR

| | | | | | |
|---|---|---|---|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM GEORGE BAKER | | | 2a. DATE OF DEATH MONTH DAY YEAR January 12, 1981 | | 2b. HOUR 30 AM |
| 3. SEX M | 4. RACE CAY | 5. DATE OF BIRTH MONTH DAY YEAR 8 OCT 21 | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | 7b. CITIZEN OF WHAT COUNTRY? U.S. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RET. DIS. POWER CO. ENERGY | | 12b. KIND OF BUSINESS OR INDUSTRY |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY DELA SUSS | | 13b. CITY OR TOWN GEORGETOWN | 13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13d. STREET ADDRESS 8 S. FRONT ST | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HARRY EDMUND BAKER | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOROTHY ELIZABETH TRACEY BAKER | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) XXXX | 17. INFORMANT ADDRESS EUNICE DEAN BAKER - SPOUSE | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Arrest</u> 1850 DUE TO, OR AS A CONSEQUENCE OF: (b) <u>metastatic carcinoma of the prostate</u> DUE TO, OR AS A CONSEQUENCE OF: (c) <u>Bilateral pneumonia</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>1/2/81</u> , 19 <u>81</u> , to <u>1/12/81</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>1/11/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/12/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Chayton L. Paulino | | 22e. ADDRESS Louis & Quincy St's Salisbury MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 15 JAN 81 | 23c. NAME OF CEMETERY OR CREMATORY REHOBOTH | | 23d. LOCATION CITY OR TOWN COUNTY STATE REHOBOTH SUSS DE | 23e. DATE REC'D. BY REGISTRAR JAN 20 1981 |
| 24. FUNERAL DIRECTOR NAME R. J. Dooe | | ADDRESS GEORGETOWN DE | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|---|---|--|---|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | |
| FIRST MIDDLE LAST AUSTIN A. BANKS | | | | | MONTH DAY YEAR HOUR 1 24 81 10 10A.M. | | | | |
| 3. SEX MALE | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9 3 86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (IF DECEASED FOR MOST OF WORKING LIFE) FARMER-SEA CAPT. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN MD. WICOMICO SALISBURY | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 108 W. LONDON AVENUE | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Granville Banks | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ESTHER WHITE | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) — | | 17. INFORMANT ADDRESS Lois Webster, 202 State St. Delmar Md 19940 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebral thrombosis</u> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yrs. |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Carcinoma of prostate</u> | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (his hospital) attended the deceased from <u>4/23/81</u> to <u>4/24/81</u> , that (I) (we) last saw the deceased alive on <u>4/23/81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>Earl M. Beardsley</u> | | | | DEGREE MD | | 22c. DATE SIGNED 1/24/81 | | 22d. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. Beardsley MD | | | | 22f. ADDRESS Civic Ave Salisbury Md | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 1/27/1981 | | White Family Cem | | Shad Point Area, Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 29 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Barry H. B...</u> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03235 | | | |
|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST James BANKS | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 28 1981 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 2 10 94 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 86 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD 13b. COUNTY Talbot 13c. CITY OR TOWN Trope | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Daniel Banks | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elmer Brummell | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) no | | | | 16b. SOCIAL SECURITY NO. --- | | 17. INFORMANT ADDRESS Emily M Banks | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: 4293 IMMEDIATE CAUSE (a) congestive heart failure DUE TO, OR AS A CONSEQUENCE OF (b) arteriosclerotic cardiovascular d. DUE TO, OR AS A CONSEQUENCE OF (c) --- Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) old CVA | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18; PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE E. P. Ritchings, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/28/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) E. P. Ritchings, M.D. | | | | 22e. ADDRESS Deer's Head Center, Salisbury. Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 2/13/81 | | 23c. NAME OF CEMETERY OR CREMATORY Paradise | | 23d. LOCATION CITY OR TOWN COUNTY STATE Trope Talbot MD | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 5 1981 | | | |



Handwritten text, possibly a signature or date, appearing as "1942" and "1943".

Handwritten text, possibly a date or number, appearing as "1942" and "1943".

Handwritten text, possibly a date or number, appearing as "1942" and "1943".

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03236 | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 4 81 | | | |
| 3. DECEASED NAME (TYPE OR PRINT) FRANK | | | | 7b. HOUR 2 35 AM | | | |
| 4. SEX male | | 5. RACE W. | | 5. DATE OF BIRTH MONTH DAY YEAR 11 25 98 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Unknown | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVERWALK MANOR | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME (FIRST MIDDLE LAST) Unknown | | 15. MOTHER'S MAIDEN NAME (FIRST MIDDLE LAST) Unknown | | 16. STREET ADDRESS 105 Times Square | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO 316-56-0576 | | 17. INFORMANT (NAME AND ADDRESS) Jean R. Monroe 10431 Washington St. P.R. Snow Hill, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Bladder 1889 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (this hospital) attended the deceased from Nov. 28 19 78 to Jan 4 19 81, that (we) lost saw the deceased alive on Jan 4 19 81, and that in (our) opinion death occurred on the date and hour and from the causes stated above (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Thomas C. Hill M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED Jan 4 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. Hill JR | | | | 22e. ADDRESS P.O. Box Bluff Road, Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | 23b. DATE 1-9-81 | | 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE LEWES SUSSEX DEL | |
| 24. FUNERAL DIRECTOR NAME JOILEY MEMORIAL CHAPEL | | ADDRESS RA 2 Jersey Rd Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03237

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|---|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Elaine BLOODSWORTH | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5, 1981 | | | 2b. HOUR 5:04 M | | | |
| 3. SEX FEMALE | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 3, 1939 | | 6. AGE (IN YEARS LAST BIRTHDAY) 41 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | |

| | | | | | | | | | | | | | | |
|---|--|--|--------------------------------------|--|--|--|--|--|---|--|--|---------------------------------------|--|--|
| 13a. STATE Maryland | | | 13b. COUNTY Somerset | | | 13c. CITY OR TOWN Princess Anne | | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> NO <input checked="" type="checkbox"/> YES | | | 13e. STREET ADDRESS Route 3 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Randall Owens | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Velma Hanks | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | 16b. SOCIAL SECURITY NO. ? | | | 17. INFORMANT ADDRESS Route 3 Mr. Walter Bloodsworth, Princess Anne | | | | | | | | |

| | | | |
|--|--|---|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) METASTATIC MELANOMA - BRAIN - 1729 DUE TO, OR AS A CONSEQUENCE OF, Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) MALIGNANT MELANOMA - SKIN - DUE TO, OR AS A CONSEQUENCE OF (c) | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs. | |
|--|--|---|--|

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

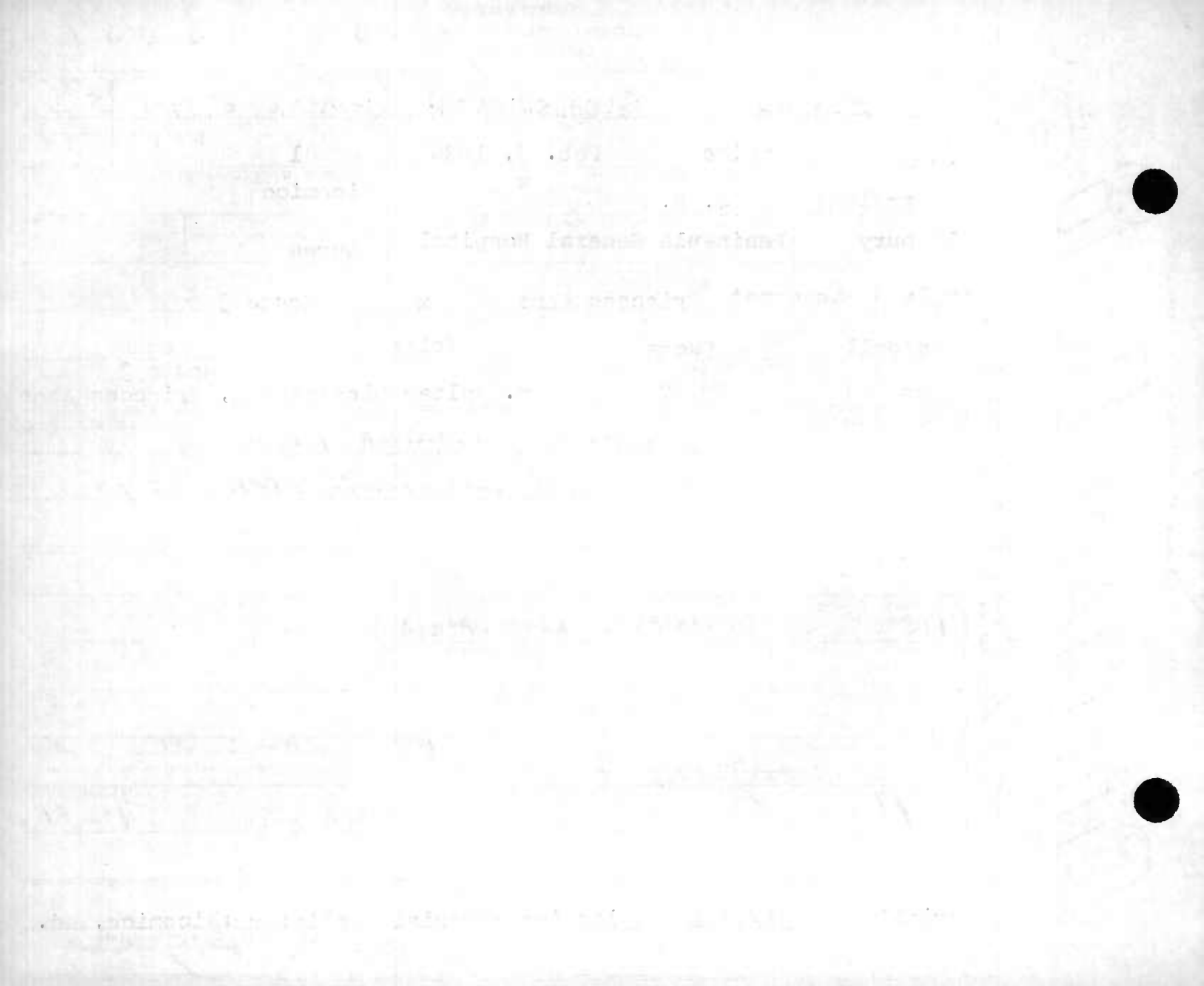
| | | | | | | | |
|---|--|---|--|--|--|--|--|
| 19a. DATE OF OPERATION 1980 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED METASTASIS - NECK + AXILLA | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1980 , to JAN 5, 1981 , that (I) (we) last saw the deceased alive on JAN 4, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE H. Ray Lewis | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 5/2/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |

| | | | | | | | |
|---|--|----------------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/7/81 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury; Wicomico, Md. | |
| 24. FUNERAL DIRECTOR NAME James L. Herman | | | | ADDRESS Princess Anne Md | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE JAN 9 1981 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 1 0 3 2 3 8 | | | |
|--|--|--|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Aderson -- | | | | 2b. DATE OF DEATH MONTH DAY YEAR JANUARY 12, 1981 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 23, 1903 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 77 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James A. Boggs | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Emila R. Dittmeyer | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 440-18-8341 | | 17. INFORMANT ADDRESS Mrs. Hazel C. Boggs (wife) same as 13 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 Conditions, if any, which gave rise to immediate cause (b), stating the underlying cause lost. (b) <u>Decompensated Congestive Heart Failure</u> (c) <u>Arteriosclerotic heart disease</u> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) the hospital attended the deceased from <u>1/5/81</u> , 19 <u>81</u> , to <u>1/12</u> , 19 <u>81</u> , that (2) the deceased above (1) (we) (did) (did not) view the body after death, and that in my (our) opinion death occurred on the date and hour and from the causes stated | | | | | | | |
| 22b. SIGNATURE <u>Charles L. Raab</u> | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Charles L. Raab M.D. | | | | 22e. ADDRESS Lousie & Quincy St's Salisbury MD | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/14/81 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Wic., Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | | |

8000000

Engineering General Hospital

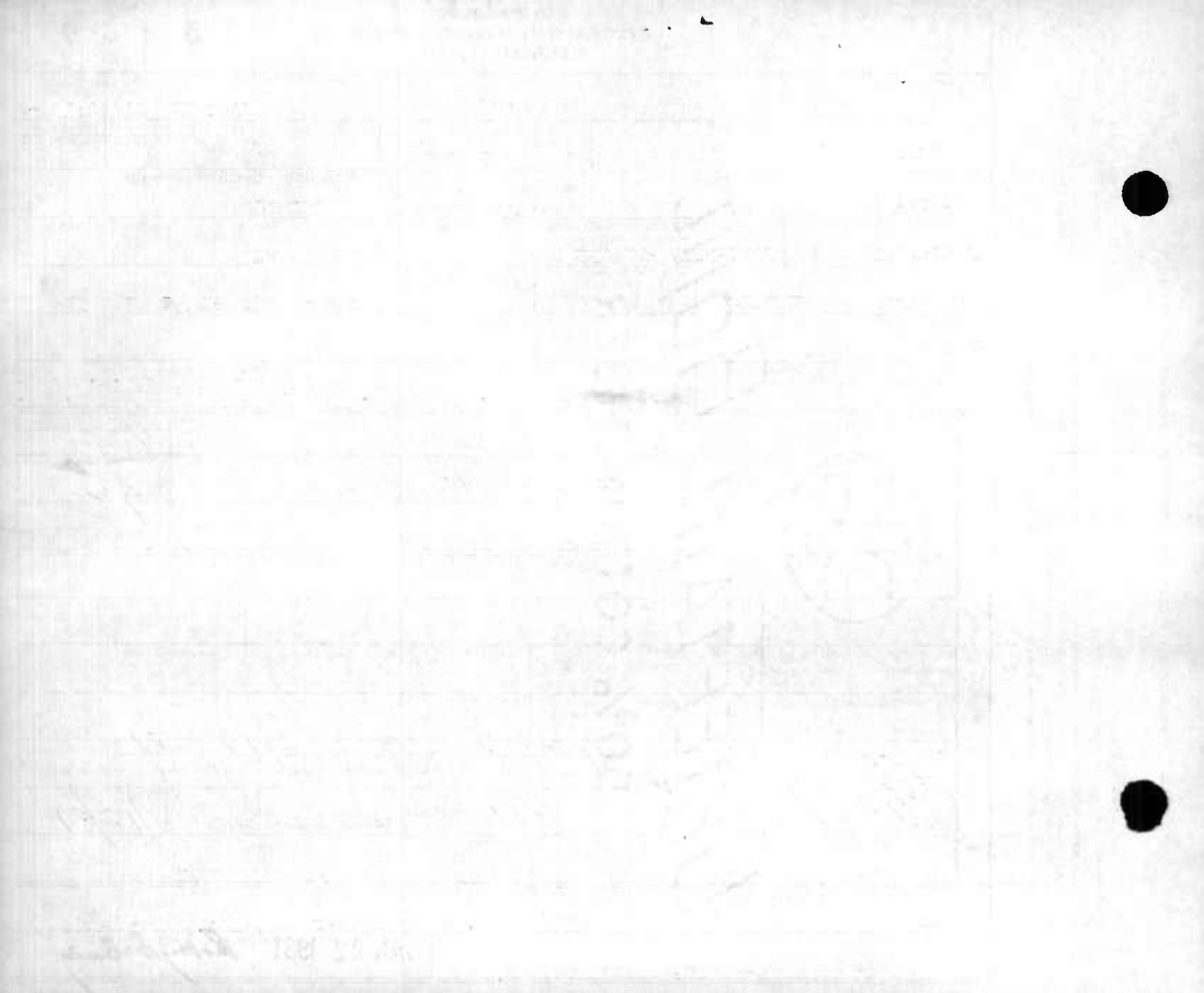
1900 - 1901

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 1 0 3 2 3 9 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST EFFA Belle BRADLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN. 17 81 | | | 2b. HOUR 4:15 PM | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 12 07 1886 | | 6. AGE (IN YEARS LAST BIRTHDAY) 94 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY WICOMICO 13c. CITY OR TOWN Mardela | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 7 Bridge Street, BOX 57 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel James Phillips | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Ellen Cox | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-32-0665D | | 17. INFORMANT ADDRESS Mr. Melvin J. Bradley (son) Salisbury, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line in (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Arterial Thrombosis</i> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <i>generalized arteriosclerosis</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>yc</i> | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 7/16/81 to 1/17/81, that (I) (we) last saw the deceased alive on 1/16/81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE <i>Earl M. Beardsley</i> | | 22b. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY | | 22c. ADDRESS CIVIC AVE. & RT. 50, SALISBURY, MD. | | 22d. DATE SIGNED 1/18/81 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/20/81 | | 23c. NAME OF CEMETERY OR CREMATORY Mardela Mem. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Mardela Wic. Maryland | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE RECD. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Robert McBrady</i> | | | |



1000 1000

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03240 | | | |
|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST William James Bradley | | | | January 31, 1981 | | | |
| 3. SEX male | | | | 2b. HOUR 7:25 AM | | | |
| 4. RACE White | | | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 | | | |
| 5. DATE OF BIRTH MONTH DAY YEAR Sept. 3, 1899 | | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | |
| 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Auto Mechanic | | | |
| 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | | 13b. CITY OR TOWN Salisbury | | | |
| 13c. COUNTY Wicomico | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13e. STREET ADDRESS 312 E. William St. | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Francis Waters Bradley | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Nettie Evalene Catlin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? YES NO OR UNKNOWN NO | | | | 16b. SOCIAL SECURITY NO. 214-30-8075 | | | |
| 17. INFORMANT 403 Cedar St. Georgetown, Del. | | | | Mrs. Iris Timmons (daughter) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) - 4850 - Bronchopneumonia extensive with DUE TO, OR AS A CONSEQUENCE OF (b) - Same Hypoxia Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) - PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) - acute Primary edema - | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | |
| 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | |
| 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | |
| 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/27, 19 81, to 1/31, 19 81, that (I) (we) last saw the deceased alive on 1/31, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE J. Badros MD | | | | 22c. DATE SIGNED 1/31/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOSEPH Z. BADROS | | | | 22e. ADDRESS 229 FLORIDA AVE SALISBURY MD 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 2/2/81 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1981 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

WISCONSIN

DEPARTMENT OF REVENUE

FEB 4 1921

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

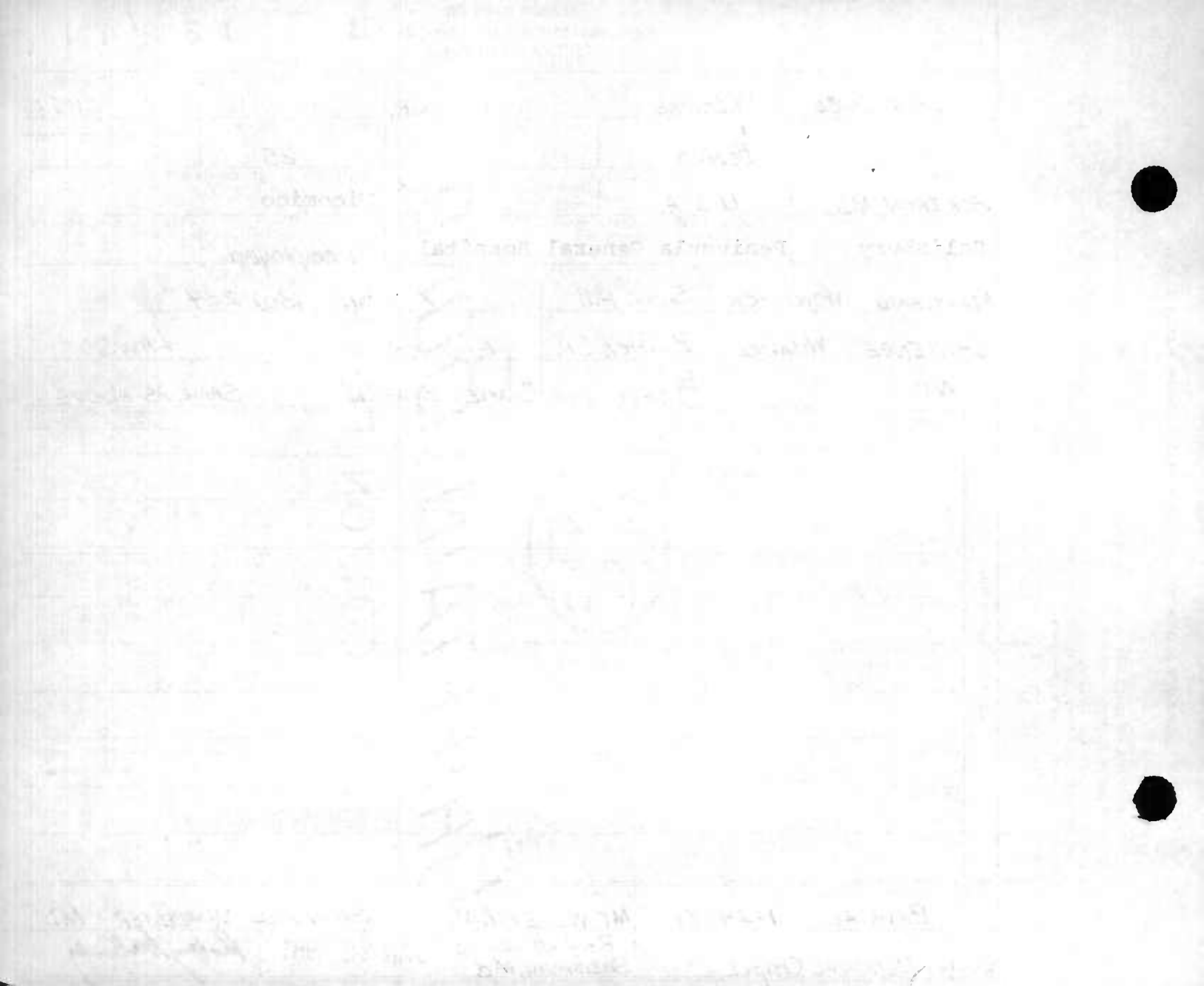
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03241 | |
|--|--|--|--|---|--|---|---|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST LAWRENCE WILMORE BRATTEN JR. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January-17-81 | | 2b. HOUR 12:05 PM | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 08 31 1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) BOX IRON, MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) unemployed | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1, Box 234 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LAWRENCE WILMORE Bratten SR. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELEANOR LAWS | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> UNKNOWN) | | | 16b. SOCIAL SECURITY NO. 900-06-2165 | | 17. INFORMANT Charles Bratten | | | ADDRESS SAME AS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hypertension severe with coma</u> 5070 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) <u>Pneumonia</u> <u>Diabetic Mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-13-</u> 19 <u>81</u> , to <u>1-17-</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1-17-</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>James L. Clifford</i> | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>1-17-81</u> | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES L. CLIFFORD | | | 22e. ADDRESS #12 MEDICAL CENTER, SALISBURY, MD | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-24-81 | | 23c. NAME OF CEMETERY OR CREMATORY MT. WESLEY U.M. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE SNOW HILL WORCESTER MD | | | |
| 24. FUNERAL DIRECTOR NAME JOILEY MEMORIAL Chapel | | | ADDRESS Rt. 2 Jersey Rd Salisbury, Md | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | | 25b. REGISTRAR'S SIGNATURE <i>Anthony M. Brady</i> | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of a case.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03242 | |
|---|--|--|-----------------------------|--|---|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Beatrice Brown | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 11, 1981 | | | | 2b. HOUR 1:40 M | | |
| 3. SEX Female | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 7-10-1913 | | 6. AGE (IN YEARS LAST BIRTHDAY) 77 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 745 Salis. Md. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James T Jenkins | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Harris | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. 219-05-0483 | | 17. INFORMANT ADDRESS Dora Chapman P.O. Box 745 Salis. Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4379 cerebral vascular micro. diabetes mellitus DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 11a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/5 , 19 81 , to 1/11 , 19 81 , that (I) (we) last saw the deceased alive on 1/11/81 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE MB Jones MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/11/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Green Acres | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic. Md. | | | |
| 24. FUNERAL DIRECTOR (NAME) Clinton F. Stewart | | | | ADDRESS West Rd Salis. Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony M. Brady | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRAR

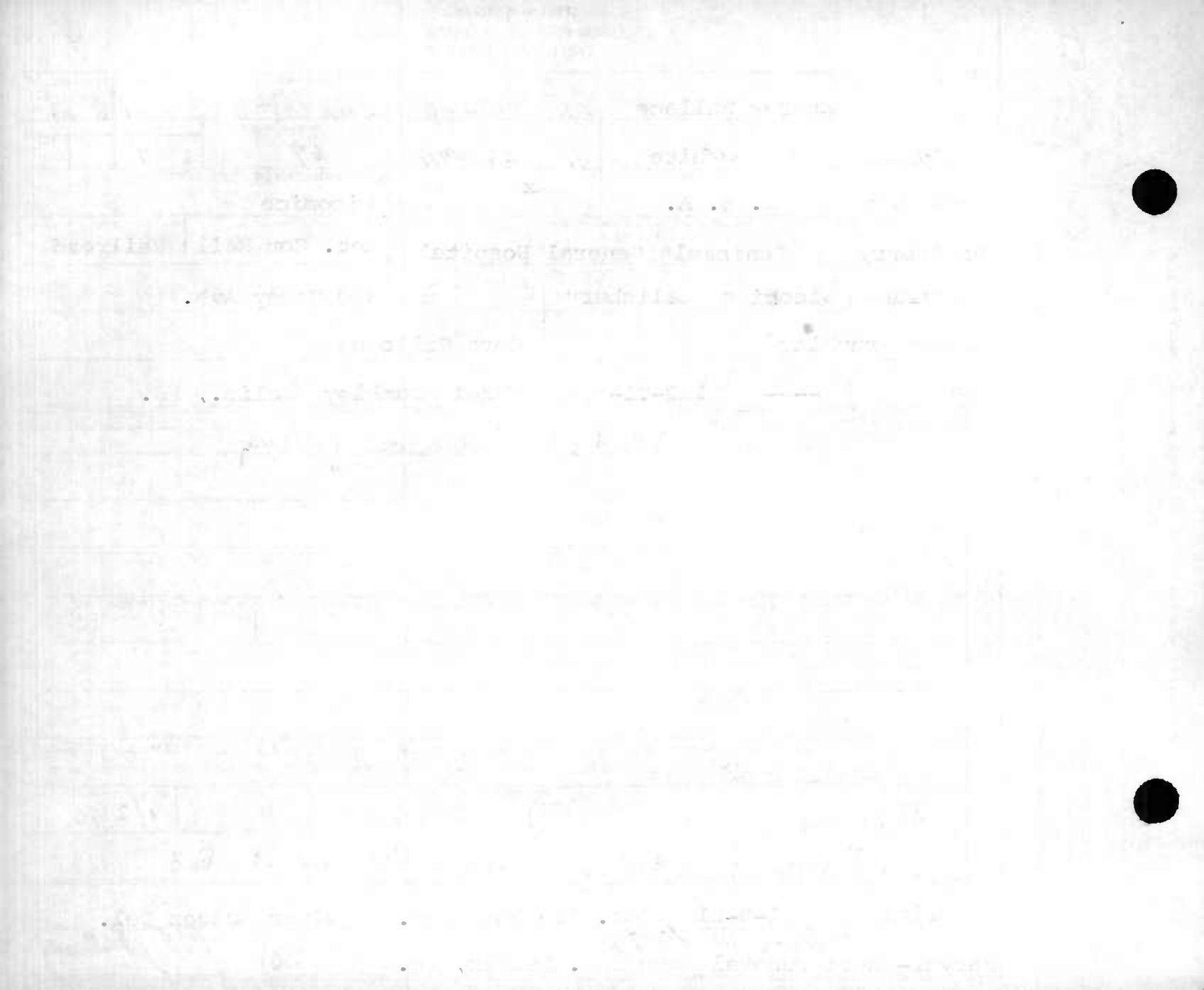
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1 03243

| | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Andrew Wallace | | FIRST BRUMBLEY | | MIDDLE BRUMBLEY | | LAST BRUMBLEY | | 2a. DATE OF DEATH MONTH JANUARY | | DAY 3 | | YEAR 1981 | | 2b. HOUR 8:35 M | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 11 | | DAY 26 | | YEAR 1911 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 | | IF UNDER 1 YEAR MONTHS 1 | | IF UNDER 72 HRS. DAYS 7 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Con Rail | | 12b. KIND OF BUSINESS OR INDUSTRY Railroad | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS 300 Carey Ave. | | | | | | | |
| 14. FATHER'S NAME FIRST Isaac MIDDLE Brumbley LAST Brumbley | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Cora MIDDLE Calloway LAST Calloway | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) ----- | | 17. INFORMANT ADDRESS Hazel Brumbley Salis., Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Small Cell Carcinoma of lung 1629 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/25 , 19 80 , to 1/3 , 19 81 , that (I) (have) lost saw the deceased alive on 1/2 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) did (not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | | 22c. DATE SIGNED 1/3/80 | | | | 22d. ADDRESS 1300 S. Division St Exd. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-5-81 | | | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del. | | | |
| 24. FUNERAL DIRECTOR NAME William M. Marvel-Short | | | | 25a. DATE REC'D. BY REGISTRAR De. JAN 7 1981 | | | | 25b. REGISTRAR'S SIGNATURE <i>William M. Marvel-Short</i> | | | | | | | |

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | | | | |
|--|--|--|--|---|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Brown Clarence E. Brown | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18, 1981 | | | 2b. HOUR 10⁴⁰ P^M | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 30, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 88 1 18 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Railroad | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Noah James Brown | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Brown | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 222-01-5254 | | 17. INFORMANT ADDRESS Oscar E. Brown Pittsville, Md. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) generalized arteriosclerosis; dehydration 4409 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15 , 19 81 , to 1/18 , 19 81 , that (I) (we) lost saw the deceased alive on 1/15 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Dr. Ben Homer MD | | | | DEGREE MD | | 22c. DATE SIGNED 1/18/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-21-81 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del. | | |
| 24. FUNERAL DIRECTOR NAME William M. Short | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |
| 26. FUNERAL HOME Marvel-Short Funeral Home Delmar, Del. | | | | | | | | |

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JAN 8 1981

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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|--|--|---|---|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 03245 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Martha Emily Butler | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 23, 1981 | | | | | 2b. HOUR 11 23 P M | |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Sept. 10, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Prince Anne | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James H. Ruark | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Aurora Riggin | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Rt. 2 Mrs. Winnie Evans, Snow Hill, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Pneumonia DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4860 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) urinary diabetes mellitus | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-19 , 19 81 , to 1-23 , 19 81 , that (I) (we) last saw the deceased alive on 1-23 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE W. O. [Signature] | | | | | DEGREE M.D. | | | 22c. DATE SIGNED 1-23-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/28/81 | | 23c. NAME OF CEMETERY OR CREMATORY Perryhawkin | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Prince Anne Somerset Md. | | | |
| 24. FUNERAL DIRECTOR NAME James L. [Signature] | | | | | ADDRESS Prince Anne | | 25. RECEIVED BY REGISTRAR JAN 28 1981 | | REGISTRAR'S SIGNATURE [Signature] | | |

1001, 1002, 1003

1004, 1005, 1006

1007, 1008, 1009

1010, 1011, 1012

1013, 1014, 1015

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1019, 1020, 1021

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 1 0 3 2 4 6 | | | |
|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Margaret JONES COLLIER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-25-81 | | 2b. HOUR 9:10 AM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9-20-91 | | 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Chester, Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | | 12b. KIND OF BUSINESS OR INDUSTRY OWN Home | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury | | | | 14. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 15. STREET ADDRESS 218 S. BLVD | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Samuel G Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lula Jones | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 217-48-7524 | | 17. INFORMANT ADDRESS Mrs. Thelma Moore 218 S. BLVD. Salisbury, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Cerebral thrombosis DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk yes. | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/27, 1978, to 1/25, 1981, that (I) (we) lost saw the deceased alive on 1/24, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. EARL M. BEARDSLEY | | | | 22c. DATE SIGNED 1/26/81 | | 22d. ADDRESS CIVIC AVE, SALISBURY, MD. 21801 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-27-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Dorchester Mem PK | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dor. MD. | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds Salisbury, Md. | | | | 25. DATE REC'D. BY REGISTRAR JAN 29 1981 | | 26. REGISTRAR'S SIGNATURE [Signature] | |

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UNITED STATES OF AMERICA
DEPARTMENT OF AGRICULTURE
BUREAU OF PLANT INDUSTRY

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TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

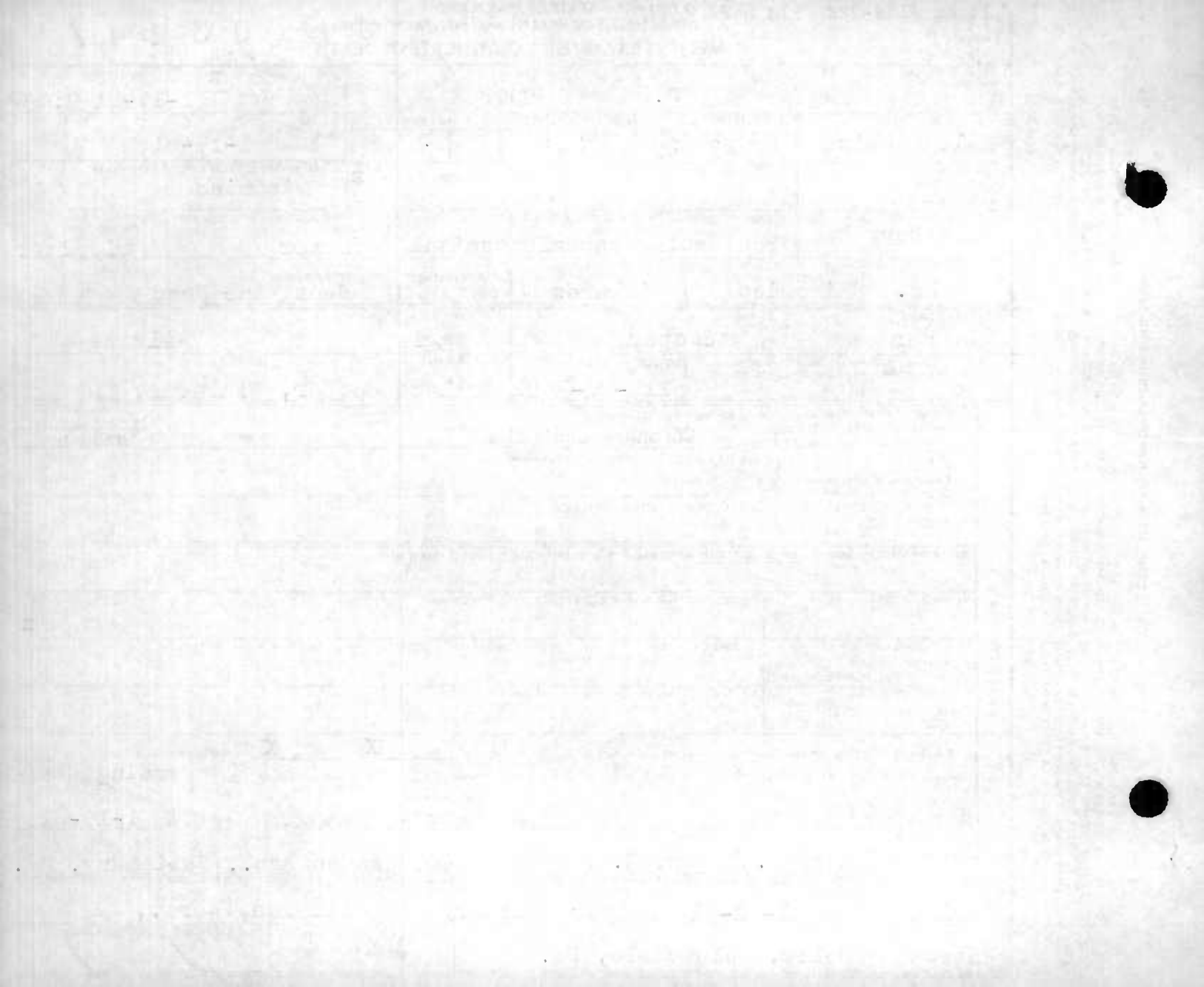
Items #10a-22a Film G522 2/17/81 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1- STATE REGISTRAR

03247
REG. NO.

| | | | | | | | |
|---|------------------|--|--|---|---|--|---|
| 1. DECEASED NAME (TYPE OR PRINT) ROY J. COOPER | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> ESTI- MATED <input type="checkbox"/> 1-17-81 9:03P | | | 2b. HOUR | |
| 3. SEX Male | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR 8 23 25 | 6. AGE (IN YEARS, LAST BIRTHDAY) 55 YRS. | IF UNDER 1 YR. MONTHS DAYS | IF UNDER 24 HRS. HOURS MIN. | 2c. DATE PRONOUNCED DEAD 1-17-81 19 | 2d. HOUR 11 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Agriculturer |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Willards | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS Bent Pine Road | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Etcher Cooper | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Maggie Wilkins | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 218-20-7492 | | 17. INFORMANT ADDRESS Wallace Cooper, Willards, MD | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a). Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) (c) | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> Pending | | | | | | | |
| ACTUAL SIGNATURE | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | DATE SIGNED 1-19-81 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-20-81 | | 23c. NAME OF CEMETERY OR CREMATORY Cooper Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Willards, Worco., MD | |
| 24. FUNERAL DIRECTOR NAME Watson & Whaley, Selbyville, De. | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 7 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

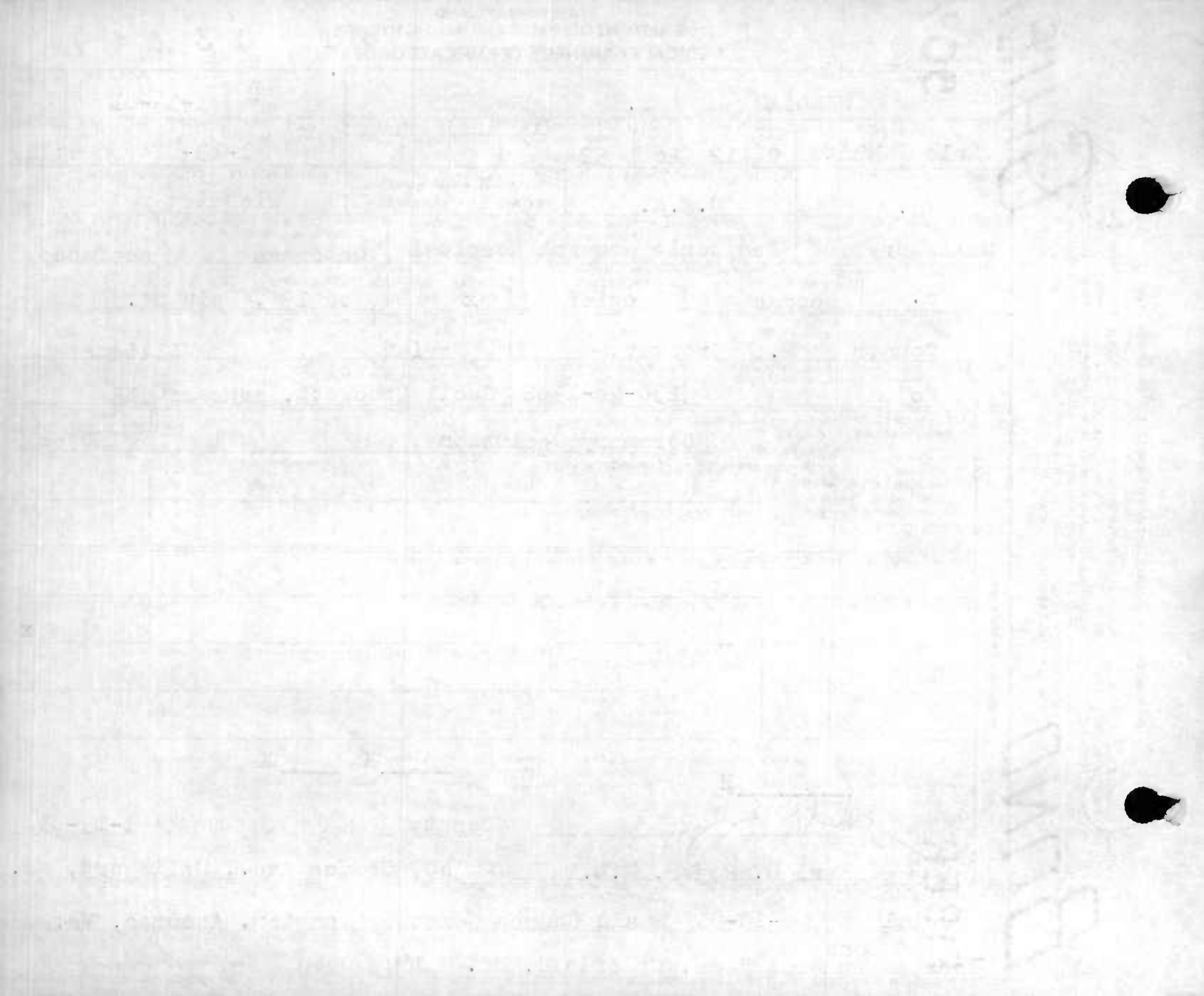
| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|---|--|--|---|---|--|--|---|--|---|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 03248 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Anna Mae CRAIN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 18, 1981 | | | 2b. HOUR 6:20 PM | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 9, 1927 | | 6. AGE (IN YEARS LAST BIRTHDAY) 54 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow Hill, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Clerk & housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE Maryland | | | | | 13b. CITY OR TOWN Salisbury | | 13c. STREET ADDRESS Rt. 1, Box 32, Riverside Dr. Ext | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward Thomas Carey | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lillian Ann Taylor | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mr. Calvin H. Crain (husband) same as 13 | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic duct cell Ca of breast</u> 1749 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 2 yrs |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Nancy W. Tustin, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/18/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D. | | | | | | 22e. ADDRESS Deer's Head Center; Salisbury, Md. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL Burial | | | 23b. DATE 1/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY Shad Point Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE R.D., Salisbury, Wic., Md. | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM-3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 48 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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DHMH-17
(V.R. 15 ME (5))
15M 7/76

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03249 REG. NO. | |
|--|--|---|--|---|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) WILLIAM T. CROCKETT | | | | | | 2a. DATE OF DEATH KNOWN <input type="checkbox"/> ESTIMATED <input type="checkbox"/> 1-13-81 | | 2b. HOUR 8 P | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH 9 DAY 12 YEAR 28 | | 6. AGE (IN YEARS) LAST BIRTHDAY 52 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD 1-13-81 19 9:14P | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) waterman | | 12b. KIND OF BUSINESS OR INDUSTRY seafood | | | |
| 13a. STATE Va. | | 13b. COUNTY Accomac | | 13c. CITY OR TOWN Tangier | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Box 135, Main St. | | | |
| 14. FATHER'S NAME FIRST Connor MIDDLE R. LAST Crockett | | | | 15. MOTHER'S MAIDEN NAME FIRST Mariah MIDDLE Williams LAST Williams | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 230-48-1362 | | 17. INFORMANT (wife) ADDRESS Cecil Crockett, same as #13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) _____ | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 1-15-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE 1-16-81 | | 23c. NAME OF CEMETERY OR CREMATORY Swain Church Cemetery Tangier, Accomac, Va. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME & Sons ADDRESS Bradshaw Funeral Home, Crisfield, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | | | | 25b. REGISTRAR'S SIGNATURE <i>Robert McCreedy</i> | | | |

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03250 | | | |
|---|--|---|--|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Jennie Crowther | | | | 2a. DATE OF DEATH MONTH DAY YEAR Jan. 30, 1981 | | | |
| 3 SEX Female | | 4 RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR 10 02 07 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | |
| 10 CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverwalk Manor | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housework | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 13a. STATE Maryland | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Oxford | | 13e. STREET ADDRESS Strand | |
| 14 FATHER'S NAME FIRST MIDDLE LAST William Russell Kelly | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Louise Lampman | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 074 03 3381B | | 17. INFORMANT ADDRESS Mr. F. D. Crowther, Oxford, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF (b) cerebral arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Days 425 | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from April 29, 1976 to Jan 30, 1981 , that (I) (we) last saw the deceased alive on Jan 30, 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John G. Bulkeley M.D. | | | | DEGREE M.D. | | 22c. DATE SIGNED 1-31-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John G. Bulkeley, M.D. | | | | 22e. ADDRESS Salisbury, Maryland | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY Viewland Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rotterdam New York | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 6 1981 25b. REGISTRAR'S SIGNATURE | | | |

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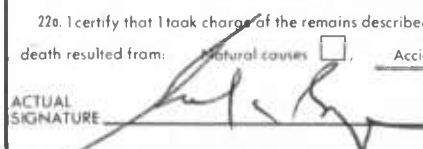
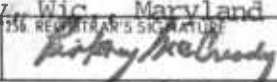
TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

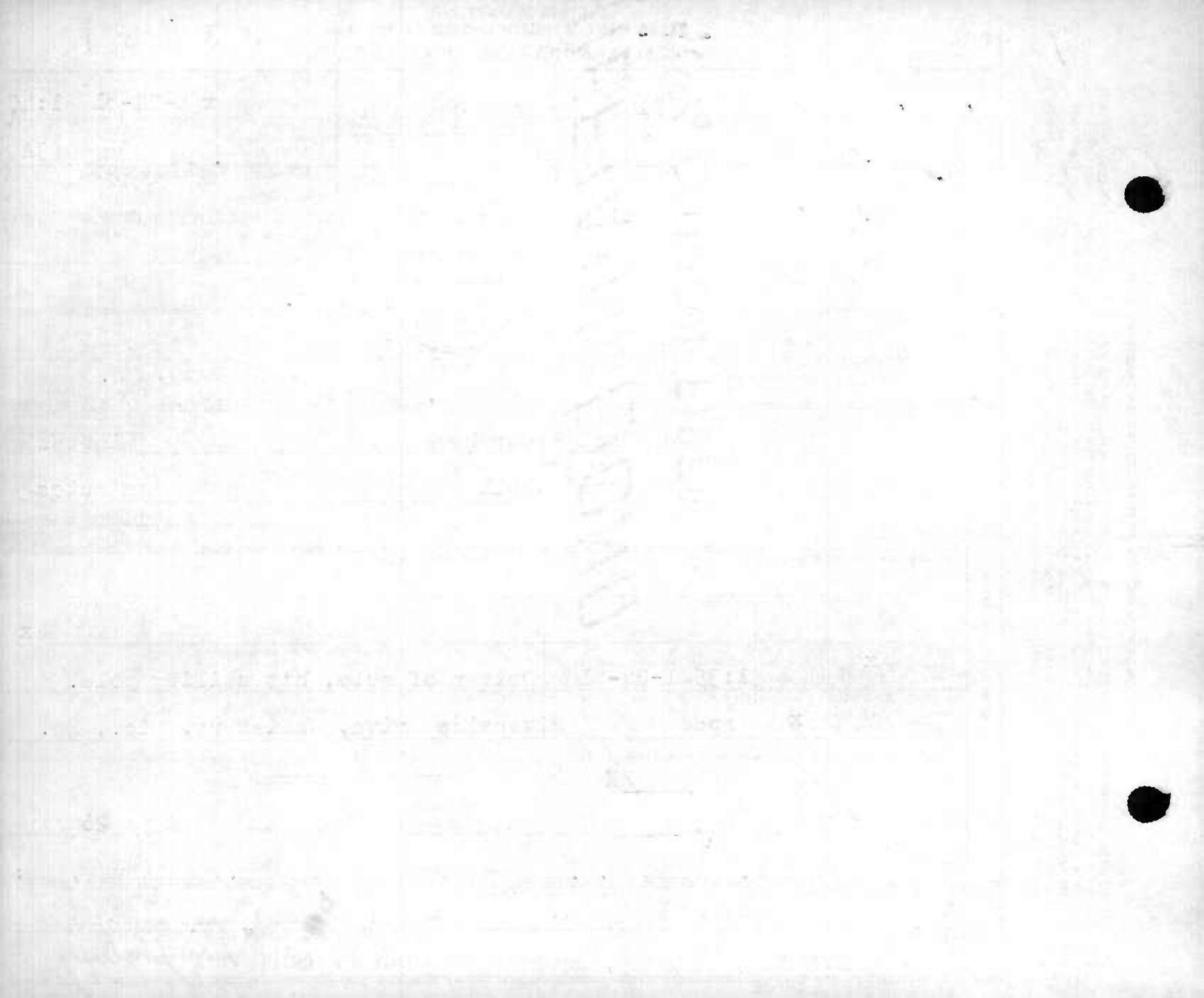
BP

DMMH - 17
(VR A15 ME (5))
15M2/80

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03251
REG. NO.

| | | | | | | | | | | | | | | | | | |
|---|--|---|--|--|--|---|--|---|--|--|--|---|--|---|--|---|--|
| 1. FOR STATE REGISTRAR | | 2. DECEASED NAME FIRST MIDDLE LAST Jeffery Hamilton Daugherty | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED 1-24-81 | | | | 2b. HOUR 1:40 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 11/21/1962 | | 6. AGE (IN YEARS) LAST BIRTHDAY 18 YRS. | | 7. IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | | 7c. DATE PRONOUNCED DEAD Jan. 24 1981 | | | | 7d. HOUR 3A PM | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Student | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 500 S. Camden | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Alexander Hamilton Daugherty | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Beverly Virginia Squyers | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | | | 17. INFORMANT Address Salisbury, Md. Mrs. Beverly Daugherty (mother) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Hemorrhage 8150 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) Fractured Skull (c) | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 1:35 PM 1-24-81 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) Driver of auto, hit utility pole. | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) road | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE Riverside Drive, Salisbury, Wic., Md. | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | DATE SIGNED 1/26/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/27/81 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland | | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the health department after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03252

| | | | | | | | | |
|--|--|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ADDIE LEE DAVIS | | | January 31, 1981 | | | 8:00 P | | |
| 3. SEX FEMALE | | | 4. RACE NEGRO | | | 5. DATE OF BIRTH MONTH DAY YEAR 3 4 91 | | |
| 6. AGE (IN YEARS LAST BIRTHDAY) 89 YRS. | | | 7. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | 8. IF UNDER 1 YEAR IF UNDER 24 HRS. MONTHS DAYS HOURS MIN. | | |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Dublin, GA | | | 9b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 10. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Unemployed | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY Wicomico | | | 13c. CITY OR TOWN Salisbury | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Frank Osborne | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie | | | 16. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 17a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 17b. SOCIAL SECURITY NO. 264-98-9327 | | | 17c. INFORMANT Mary E. Davis | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac arrhythmia or infarction DUE TO, OR AS A CONSEQUENCE OF (b) Atherosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c) Atherosclerosis | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Hours Years Years | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Sepsis, Hypothermia, senility | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/30 19 81 , to 1/31 19 81 , that (I) (we) last saw the deceased alive on 1/31 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | |
| 22b. SIGNATURE Constante J Tan | | | DEGREE M.D. | | | 22c. DATE SIGNED 1/31/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) CONSTANTE J TAN | | | 22e. ADDRESS 547-D Riverside Dr. Salisbury | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2-8-81 | | | 23c. NAME OF CEMETERY OR CREMATORY Green Acres Mem. Pk. | | |
| 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md | | | 23e. DATE REC'D. BY REGISTRAR FEB 8 1981 | | | 23f. REGISTRAR'S SIGNATURE [Signature] | | |
| 24. FUNERAL DIRECTOR NAME JOEY MEMORIAL CHAPEL | | | ADDRESS Rt. 2 Jersey Rd Salisbury, Md | | | | | |

18

Generalissimo

Handwritten signature

1878

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

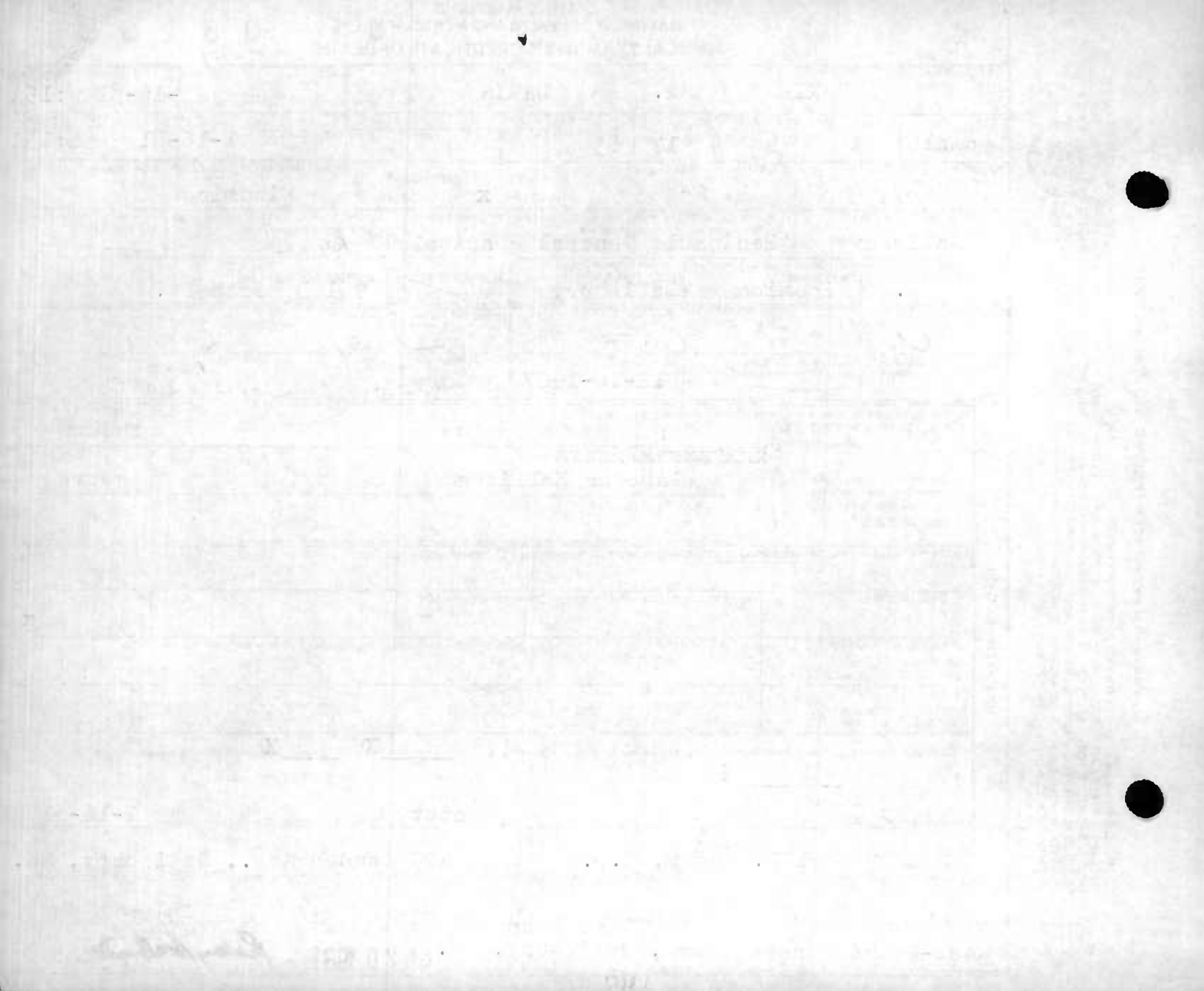
BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03253
REG. NO.

| | | | | | |
|---|---------------|--|---|---|------------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | 2c. DATE PRONOUNCED DEAD | | 2d. HOUR | |
| FIRST ROXIE | | MONTH 1-16-81 | | YEAR 1981 | |
| MIDDLE A. | | DAY 16 | | HOUR 4:15A | |
| LAST DAVIS | | YEAR 19 | | MIN 15A | |
| 3. SEX Female | 4. RACE AA | 5. DATE OF BIRTH MONTH 4 | 6. AGE (IN YEARS) LAST BIRTHDAY 9 | 7. IF UNDER 1 YR. MONTHS 17 | 8. IF UNDER 24 HRS. HOURS 63 |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Retired | |
| 13a. STATE Md. | | 13b. CITY OR TOWN Wicomico | | 13c. STREET ADDRESS 901 D Booth St. | |
| 14. FATHER'S NAME FIRST William | | 15. MOTHER'S MAIDEN NAME FIRST DAISEY | | 16. SOCIAL SECURITY NO. 212-16-1907 | |
| 17. INFORMANT ADDRESS Davis Salisbury | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4100 Coronary Occlusion (b) Diabetes Mellitus (c) DUE TO, OR AS A CONSEQUENCE OF | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | TITLE (SPECIFY) Deputy | | DATE SIGNED 1-16-81 | |
| EXAMINER'S NAME (TYPE OR PRINT) | | ADDRESS | | MEDICAL EXAMINER | |
| Earl L. Royer, M.D. | | 409 Camden Ave., Salisbury, Md. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-24-81 | | 23c. NAME OF CEMETERY OR CREMATORY Isabel Memorial Cam | |
| 24. FUNERAL DIRECTOR NAME West-Fooks Funeral Home, Salisbury, Md | | 23d. LOCATION CITY OR TOWN Salisbury | | 23e. COUNTY Wicomico | |
| 25a. DATE REC'D. BY REGISTRAR JAN 20 1981 | | 25b. REGISTRAR'S SIGNATURE R. J. H. H. | | 25c. STATE Md | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03254

1. FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Helen Sara DAY | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18, 1981 | | | 2b. HOUR 11:45 PM | |
| 3. SEX FEMALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 18, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Salisbury, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hsp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Robert T. Green | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertha Edna Givins | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-05-5870 | | 17. INFORMANT ADDRESS Mr. Ford W. Day (husband) same as 13 | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART 1. DEATH WAS CAUSED BY:

4920 IMMEDIATE CAUSE (a) acute respiratory failure
DUE TO, OR AS A CONSEQUENCE OF
(b) emphysema
DUE TO, OR AS A CONSEQUENCE OF
(c)

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

12 hr.

10 years

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1B, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>August</u> , 19 <u>77</u> , to <u>Jan 18</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan 17</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE William J Nagel MD | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-18-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) WILLIAM J NAGEL, MD | | | | 22e. ADDRESS Peninsula General Hsp. Salisbury Md. | | | |

| | | | | | | | |
|---|--|----------------------|--|--|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens, Salisbury, Wic., Maryland | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE R. J. McBrady | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified by phone.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 8 1 0 3 2 5 5 REG. NO. | | | | | | | |
|--|--|--|--|--|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>John L. DeGruchy</u> | | | | 2a. DATE OF DEATH MONTH <u>1</u> DAY <u>31</u> YEAR <u>81</u> | | | | 2b. HOUR <u>2:55</u> AM <input checked="" type="checkbox"/> PM <input type="checkbox"/> | | | |
| 3. SEX <u>male</u> | | 4. RACE <u>W.</u> | | 5. DATE OF BIRTH MONTH <u>4</u> DAY <u>17</u> YEAR <u>04</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>76</u> YRS. XXX | | IF UNDER 1 YEAR MONTHS <u></u> DAYS <u></u> | | IF UNDER 24 HRS. HOURS <u></u> MIN. <u></u> | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>Maryland</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Salis. Md.</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>River Walk Manor</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>carpenter</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | 13a. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>126 Hanson St.</u> | | | | | |
| 13a. STATE <u>Md.</u> | | 13b. COUNTY <u>Talbot</u> | | 13c. CITY OR TOWN <u>Easton</u> | | | | | | | |
| 14. FATHER'S NAME FIRST <u>Carlton</u> MIDDLE <u></u> LAST <u>DeGruchy</u> | | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Leona</u> MIDDLE <u></u> LAST <u>Leonard</u> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>No</u> | | 16b. SOCIAL SECURITY NO. <u>214-18-4734</u> | | 17. INFORMANT ADDRESS <u>7012 Magnolia Ave</u> <u>Charles C. DeGruchy Baltimore, Md.</u> | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>cerebrovascular accident</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Cerebral arteriosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Generalized arteriosclerosis</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 mos</u> <u>yrs</u> <u>yrs</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>march 26</u> 19 <u>76</u> , to <u>Jan 31</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>Jan 30</u> 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>John G. Bulkely</u> M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>1-31-81</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>John G. Bulkely, M. D.</u> | | | | 22e. ADDRESS <u>Salisbury, Md.</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>2-3-81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cem.</u> | | 23d. LOCATION CITY OR TOWN <u>Easton</u> COUNTY <u>Talbot</u> STATE <u>Md.</u> | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Newnam Funeral Home</u> ADDRESS <u>Easton, Md.</u> | | | | 25. DATE REC'D BY REGISTRAR <u>FEB 6 1981</u> | | | | 25b. REGISTRAR'S SIGNATURE | | | |

BP



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|---|--|--|--|--|---|--|--|---|------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Chauncy Dickerson | | | 2a. DATE OF DEATH MONTH DAY YEAR January 18 1981 | | | 2b. HOUR 8:53 M | | | | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR June 10, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Va. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 5th St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Ewell, Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margie Dickerson | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | 16b. SOCIAL SECURITY NO. 189-09-5636 | | 17. INFORMANT William Ewell, Jr. | | ADDRESS Atlantic, Va. | | | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:IMMEDIATE CAUSE (a) **Cardiac Arrest & Resp Failure.****4349**

Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) **Possible Brainstem Dysfunction.**

DUE TO, OR AS A CONSEQUENCE OF

(c)

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: (a)

CAA & HIO M. Infarction and P. Edema. Hypertension.

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/18/81 , 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on 10/29 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Me | | DEGREE M.D. | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/20/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.R. Heela | | 22e. ADDRESS 614-C EASTERN SHORE Drive SALISBURY, M.D. 21801 | | | | | |

| | | | | | | | |
|--|--|-------------------------------|--|---|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) Burial | | 23b. DATE 1-24-81 | | 23c. NAME OF CEMETERY OR CREMATORY Friendship Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Wattsville Accomack Va. | |
| 24. FUNERAL DIRECTOR NAME Danuel Lee | | ADDRESS New Church, Va | | 25a. DATE REC'D BY REGISTRAR JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE Dorothy McCurdy | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



CONFIDENTIAL

ALL INFORMATION CONTAINED
HEREIN IS UNCLASSIFIED
DATE 10/10/00 BY 60322
UCBAW

CONFIDENTIAL

CONFIDENTIAL

CONFIDENTIAL

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

0 3 2 5 7

1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|--|--|--|--|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Herschell Timothy Doane | | | 2a. DATE OF DEATH MONTH DAY YEAR January 7 1981 | | | 2b. HOUR 8²⁸ M | | | |
| 3. SEX Male | | 4. RACE AA | | 5. DATE OF BIRTH MONTH DAY YEAR 5 23 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Somerset Country | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 704 Olivia St. Salisbury Md | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Lee Doane | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Harmon Doane | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 266-69-5707 | | 17. INFORMANT ADDRESS Hattie T Doane 704 Olivia St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Codine Anest 4292 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Severe Arteriosclerotic Cardio - Vascular Disease (c) Small Cell Carcinoma of Lung | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/5/80 , 19 80 , to 1/7 , 19 80 , that (I) (we) lost saw the deceased alive on 1/5/80 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joseph A. Grasso | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/7/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | | | 22e. ADDRESS 1300 S. Division St. Sals. Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY Green Acres Mem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wico md | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS West - 7006s Funeral Home, Salisbury, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE Henry A. ... | | |

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 3 should be detached for use as the burial-transit permit. Then please remove carbon copies. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

Unit

Personnel

Personnel

Personnel

Personnel

Personnel

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed in the office of the health officer after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified and a post-mortem examination required.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03258 | |
|---|--|---|--|---|--|--|--|---|--|----------------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) CHARLES ELMER DUFFY DUFFIELD | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 22, 1981 | | | 2b. HOUR 12:40 P.M. | | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 7/ 4 '86 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Snow HILL, MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) DEER'S HEAD STATE HOSPITAL | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY FARMER | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY WORCESTER | | 13c. CITY OR TOWN SNOW HILL | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS ROUTE #3, Box 260 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST CHARLES DUFFY | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JANE TAYLOR | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) NO | | | | 16b. SOCIAL SECURITY NO. 217-36-1559 | | 17. INFORMANT ADDRESS BERTIE CORBIN SAME AS ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) metastatic carcinoma, probable 1991 unknown etiology Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from 01/19, 19 81, to 01/22/ 19 81, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on 01/22 19 81, and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Nancy W. Tustin, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 01/22/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D. | | | | | | 22e. ADDRESS P.O. Box 2018, Salisbury, Md. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY MT. WESLEY U.M. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SNOW HILL WORCESTER MD | | | | |
| 24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL RD. SALIS. MD | | | ADDRESS RT. 2 Jersey | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

MEDICAL CERTIFICATION

BP

Page 10 of 10
Date: 10/10/10
Time: 10:10 AM

Subject: [illegible]
Reference: [illegible]
Location: [illegible]

Remarks: [illegible]
Remarks: [illegible]
Remarks: [illegible]

Remarks: [illegible]
Remarks: [illegible]
Remarks: [illegible]

Remarks: [illegible]
Remarks: [illegible]
Remarks: [illegible]

Remarks: [illegible]
Remarks: [illegible]
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Remarks: [illegible]
Remarks: [illegible]
Remarks: [illegible]

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 1 0 3 2 5 9 | |
|---|--|---|--|---|---|---|---|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Larry Richard Dwiggins | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 14, 1981 | | | | 2b. HOUR 6:15 P.M. | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 23, 1948 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS 32 | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Riverdale, Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Tech(systems) | | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co. | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Snow Hill | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Rt. 2-112L Nassawango Lane | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Marion Lewis Dwiggins | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Rebecca Jorden | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (IF YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. Viet Nam 219-46-9043 | | 17. INFORMANT ADDRESS Mrs. Mary C. Dwiggins (wife) same as 13 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Malignant Melanoma with 1739 DUE TO, OR AS A CONSEQUENCE OF widespread metastasis (b) _____ DUE TO, OR AS A CONSEQUENCE OF _____ (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/12 , 19 81 , to 1/14 , 19 81 , that (I) (we) last saw the deceased alive on 1/14 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN Joseph A. Grasso | | | | | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/14/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | | | | 22e. ADDRESS 1300 S. Division St Ext. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY Parklawn Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rockville, Maryland | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE Jeffrey Salbury | | | |

CONFIDENTIAL

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 WITH YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH YOUR FILES. AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03260 | |
|---|--|-----------------------------|--|---|--|--|---|--|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) HOUSTON VENIOUS ELZIE | | | | | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH <input type="checkbox"/> DAY <input type="checkbox"/> YEAR 1-27-81 | |
| 3. SEX Male | | 4. RACE AA | | 5. DATE OF BIRTH 7 19 06 | | 6. AGE (IN YEARS) 74 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | 2c. DATE PRONOUNCED DEAD 1-27-81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) CRISFIELD, MD | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Fruitland | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Brown Street | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY TRUCKER | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS P.O. Box 742 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST VENIOUS ELZIE | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY LOWE | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | | 16b. SOCIAL SECURITY NO. 218-05-8248 | | 17. INFORMANT ADDRESS LILLIAN G. ELZIE SAME AS ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Rectum with Metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | |
| 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | DATE SIGNED 1-29-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY SPRINGHILL MEM. GDN | | | 23d. LOCATION CITY OR TOWN COUNTY STATE HEBRON WICOMICO MD. | | |
| 24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md. | | | | ADDRESS Jersey Road | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

BP

DHMH - 17
(VR A15 ME (5))
15M 7/76

of 70

Brown Street

1991 8 23

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 3 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

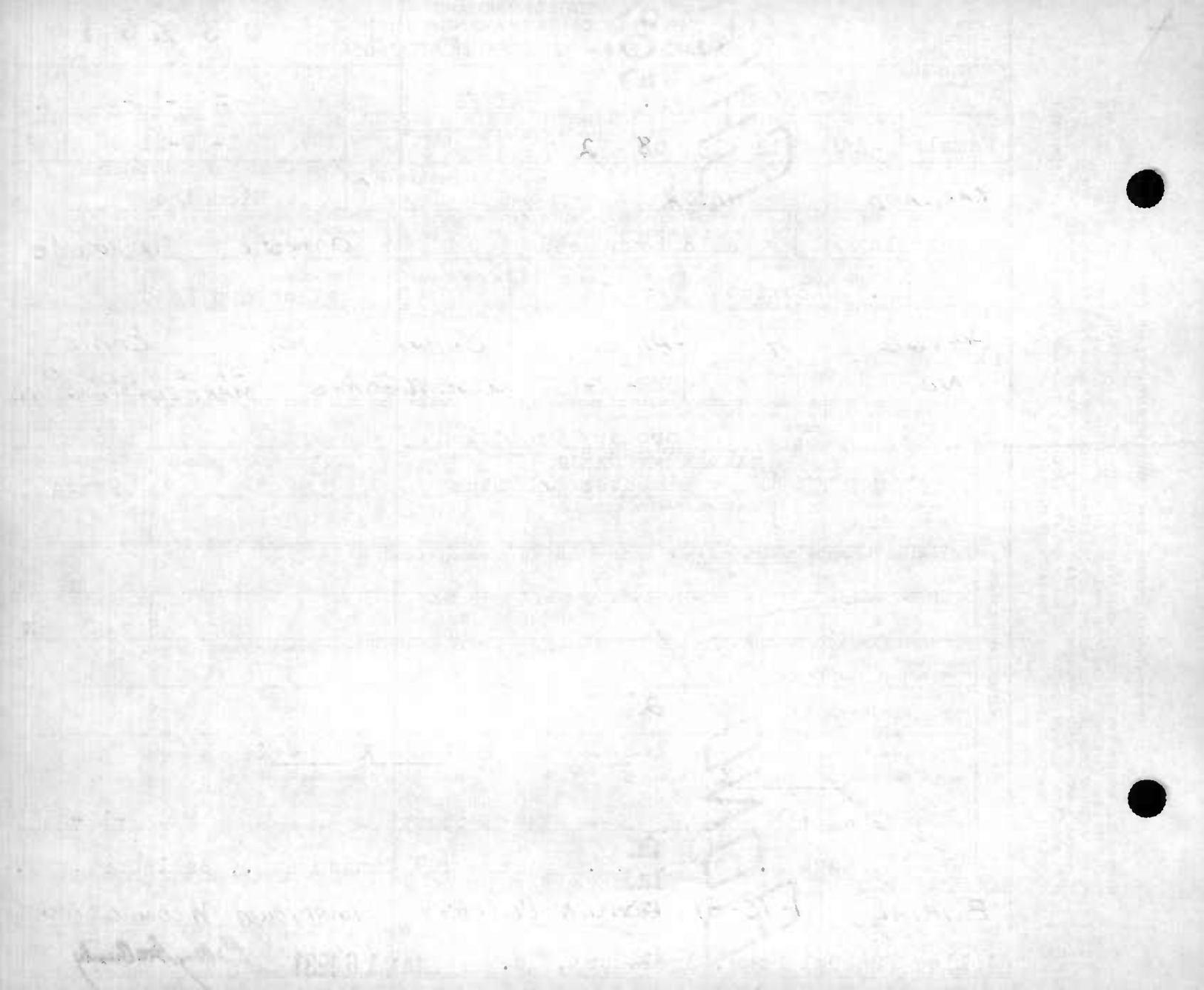
BP

DMMH - 17
(VR A15 ME (5))
15M/7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03261
REG. NO.

| | | | | | | | | | |
|---|--|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST FRANCES A. GAINES | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-10-81 | | 2b. HOUR A M | |
| 3. SEX Female | | 4. RACE AA | | 5. DATE OF BIRTH MONTH DAY YEAR 11 13 08 | | 6. AGE (IN YEARS) LAST BIRTHDAY 72 YRS. | | 7. IF UNDER 1 YR. IF UNDER 24 HRS. MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | MD. | |
| 10. CITY OR TOWN OF DEATH Mardela | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wallertown Road | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Domestic | | 12b. KIND OF BUSINESS OR INDUSTRY housewife | | | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Mardela | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Wallertown Road | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George H. GAINES | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SARAH E. Ennis | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-07-7577 | | 17. INFORMANT Jesse W. Gaines | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4100</u> Coronary Occlusion CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a) STATING THE UNDERLYING CAUSE LAST: (b) <u>Diabetes Mellitus</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Diabetes Mellitus</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years | | PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | DATE SIGNED 1-12-81 | | | |
| ACTUAL SIGNATURE Earl L. Royer | | EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-15-81 | | 23c. NAME OF CEMETERY OR CREMATORY Zion U.M. Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE SHARPTOWN Wicomico Md | | | |
| 24. FUNERAL DIRECTOR NAME Jolley Funeral Home, Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE R. J. Roberts | | | | | |

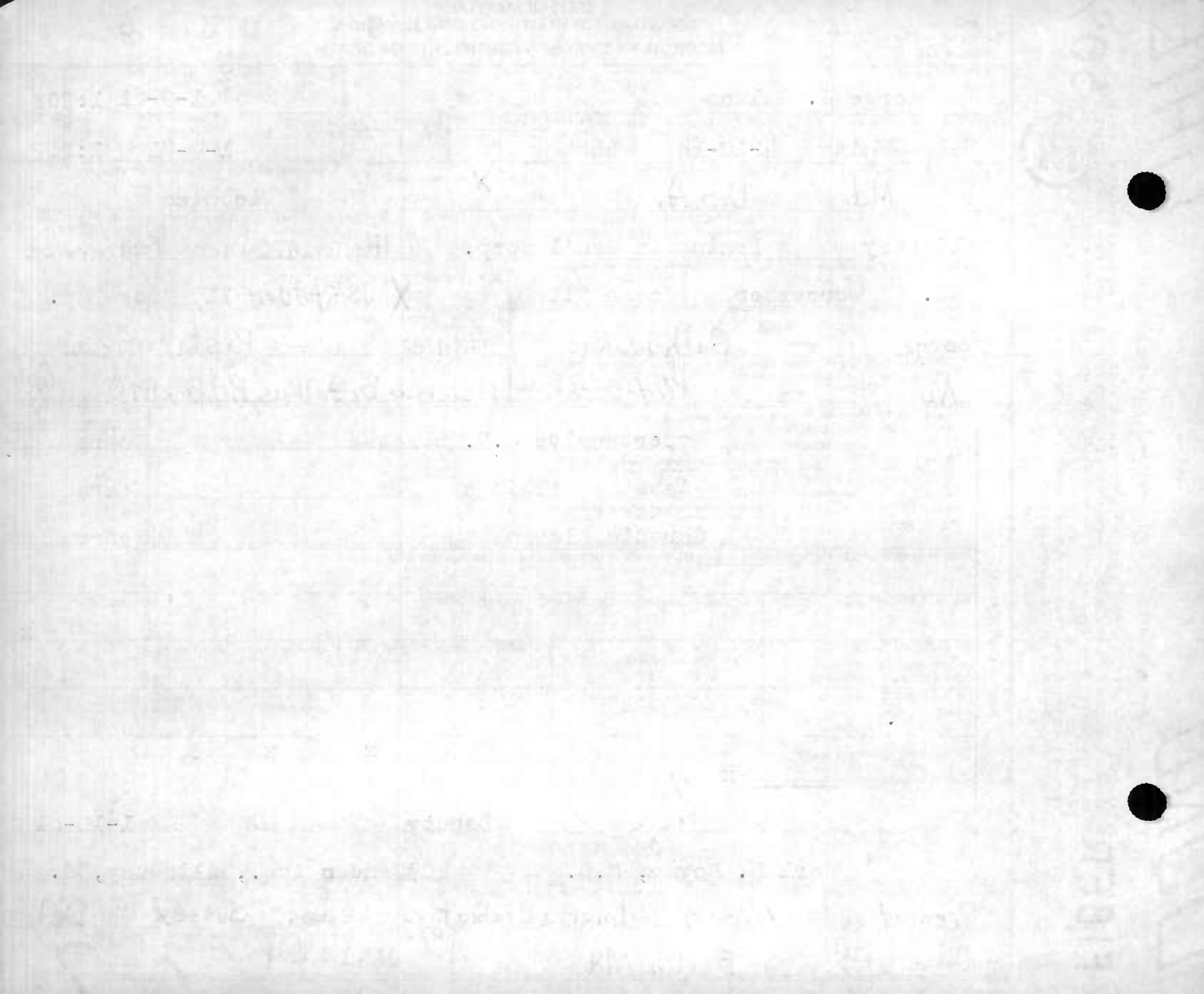


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITH 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03262 REG. NO. | |
|--|--|---|--|--|--|---|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | 20. DATE KNOWN OF DEATH | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST George J. Galkas | | | | | | | | | | 20. DATE KNOWN OF DEATH ESTI-MATED <input checked="" type="checkbox"/> 1-9-81 19:20P M | |
| 2. SEX Male | | 4. RACE White | | 3. DATE OF BIRTH MONTH DAY YEAR 4-10-14 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. 66 | | IF UNDER 1 YR. MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | 21. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-9-81 19:20P M | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula Gen'l Hosp. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Resturant Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Food Service | | | |
| 13a. STATE Md. | | | | 13b. CITY OR TOWN Worcester | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13c. STREET ADDRESS US Rt 50 Holly Grove Rd. | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George - Galkauskas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie - Pastarnokas | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 714-05-6874 | | 17. INFORMANT ADDRESS Helena B. Galkas, P.O. Box 117 Ocean City Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive C.V. Disease 4029 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Diabetes Mellitus (c) Chronic Alcoholism | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED 1-10-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes Sussex Del. | | | |
| 24. FUNERAL DIRECTOR NAME Anna A. Barboza Berlin, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

| | | | | | |
|---|---|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Mildred Givens Gearhart | | 2a. DATE OF DEATH MONTH DAY YEAR January 31 1981 | | 2b. HOUR 4:45 P.M. | |
| 3. SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 15, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Berlin, Md. | 7b. CITIZEN OF WHAT COUNTRY? USA | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Operator | | 12b. KIND OF BUSINESS OR INDUSTRY Telephone Co. |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN Salisbury | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Massey | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Alice Mae Givens | | 13e. STREET ADDRESS Rt. 3, Walston Switch Road | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT Mr. George P. Gearhart (husband) same as 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u> 4140 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Atherosclerotic heart disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Advanced Age</u> | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (1) this hospital attended the deceased from <u>4/30/81</u> 19 to <u>1/31/81</u> 19, that (2) I saw the deceased alive on <u>1/31/81</u> 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton L Raab M.D. | | 22c. ADDRESS Lanc & Quing 50's, Salisbury MD 21801 | | 22d. DATE SIGNED 1/31/81 | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/3/81 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Mem. Gardens | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed w/ the funeral director with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

(M)

Memorandum

Peninsula General Hospital

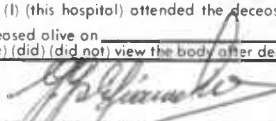
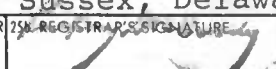
San Francisco

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03264 | | | |
|---|--|---|--|---|--|---|--|---|--|---|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | | 2b. HOUR | |
| 1. DECEASED NAME FIRST MIDDLE LAST James HUBERT GIBSON | | | | | | January 24, 1981 | | | | | | 7:00 PM | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR March 17, 1920 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Boonesville, Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Unknown | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13e. STREET ADDRESS 805 E. Church Street | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Amos Gibson | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Edna Pearl Garrison | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. WW II 219-12-4602 | | 17. INFORMANT (sister) ADDRESS Mrs. Gladys A. Embrey, 1116 Agnew Drive, Rockville, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypovolemic Shock 5789 DUE TO, OR AS A CONSEQUENCE OF (b) Upper gastrointestinal Bleeding Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 hours 24 hours | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Cardiac arrhythmias | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE  | | | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1-24-81 | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) George N. Galifianakis, M.D. | | | | 22e. ADDRESS Medical Center, Salisbury, Maryland 21801 | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | | 23b. DATE 2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Delaware | | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25. DATE RECEIVED BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | | | |

British and Foreign Medical Association

General Secretary, British and Foreign Medical Association

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.



| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|---|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | REG. NO. 03265 | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST Viola Mae Gillis | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 5 1981 | | | 2b. HOUR 17 M |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 4, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 59 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Alexandria, Va. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cashier | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 203 Clay Street | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Webster Byron Metz | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Elizabeth Cook | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 213-14-1030A | | 17. INFORMANT ADDRESS same as 13 Mr. George B. Gillis, Jr. (Husband) | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Progressive Multiple Sclerosis with Bulbar Involvement</i> 3400 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Aspiration Pulmonary Infection - Chronic Chronic tract Infection</i> | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>1-4-</i> 19 <i>81</i> , to <i>1-5-</i> 19 <i>81</i> , that (I) (we) lost saw the deceased alive on <i>1-5-</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>James H. Clifford</i> MD | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>1-5-81</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JAMES H. CLIFFORD | | | | | 22e. ADDRESS #12 MEDICAL CENTER SALISBURY MD. | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/8/81 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Barney H. H. H.</i> | | |

BP



Asst. Dir. of Investigation, FBI

Page 10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 2 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

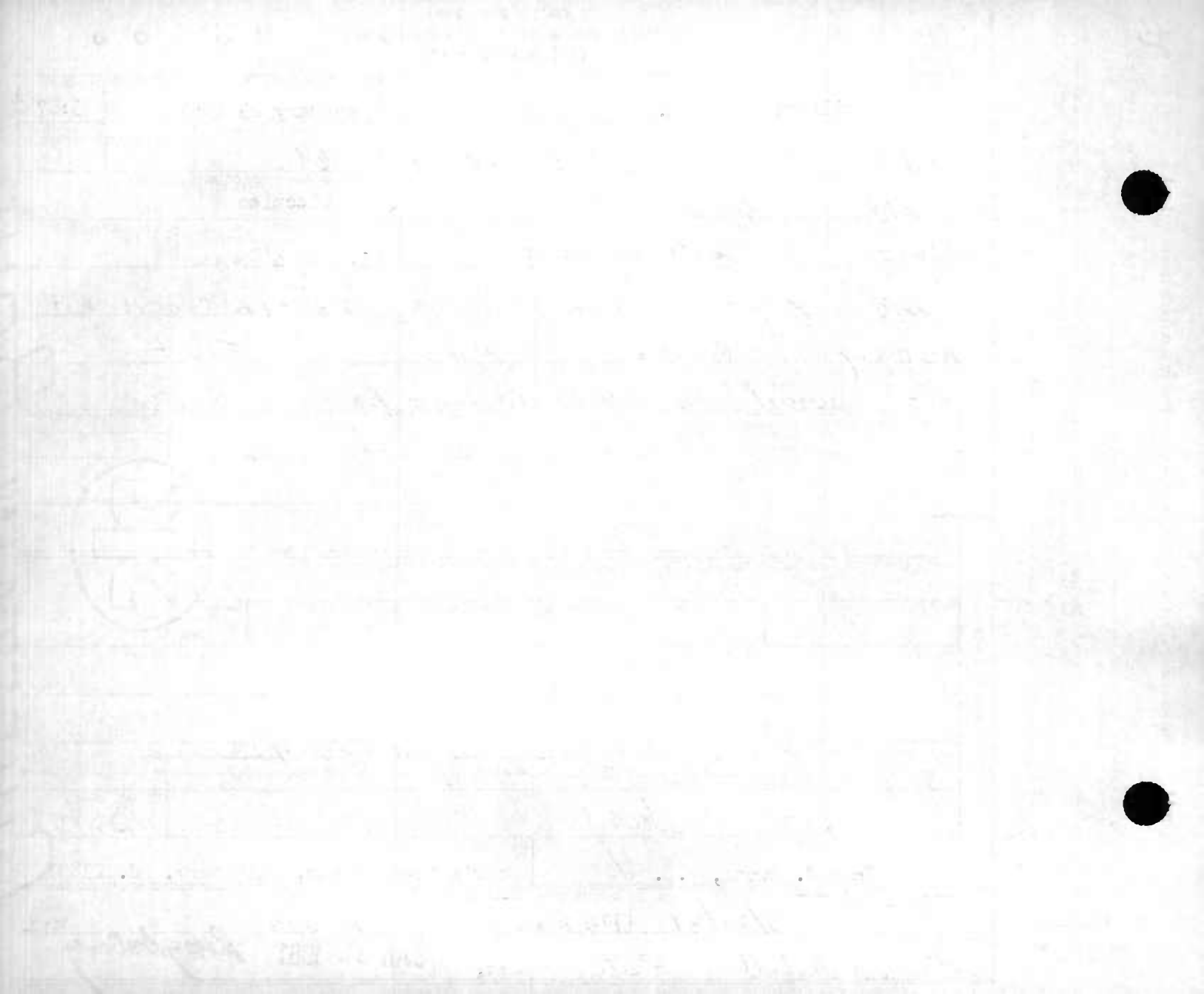
DHMH-16 30M 2/80
(VRA 15, 4)1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03266

| | | | | | | | |
|---|--|---|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Wilbert A. GROCE | | | 2a. DATE OF DEATH MONTH DAY YEAR January 23 1981 | | | 2b. HOUR 3:07 M | |
| 3. SEX Male | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR 6 28 19 | | 6. AGE (IN YEARS LAST BIRTHDAY) 61 YRS. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md | | 8. CITIZEN OF WHAT COUNTRY? USA | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD | | 10. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 11. CITY OR TOWN OF DEATH Salisbury | | 12. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | 13a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Security Guard | | 13b. KIND OF BUSINESS OR INDUSTRY | |
| 14. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 14a. STATE Md | | 14b. COUNTY 800 - Cambridge | | 14c. CITY OR TOWN Salisbury | | 14d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 15. FATHER'S NAME FIRST MIDDLE LAST Ashbury Groce | | 16. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ellis Teet | | 17. STREET ADDRESS 289-1A Concl Rd. | | 18. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) yes WWII | |
| 19. SOCIAL SECURITY NO. 221-12-4148 | | 20. INFORMANT George Anna Groce | | 21. ADDRESS | | 22. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH yrs | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic cardiovascular disease</u> 4049 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) _____ | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1, OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/15, 1980, to 1/23, 1981, that (I) (we) lost saw the deceased alive on 1/23, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Inja J. Hwang | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/23/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D. | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | |
| 23a. BURIAL CREMATION REMOVAL (SPECIFY) | | 23b. DATE 1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY Delmar | | 23d. LOCATION CITY OR TOWN COUNTY STATE Loomis Md | |
| 24. FUNERAL DIRECTOR NAME Lester H. DeCello | | ADDRESS Eaton Md | | 25. DATE REC'D. BY REGISTRAR JAN 28 1981 | | 26. REGISTRAR'S SIGNATURE Lester H. DeCello | |

MEDICAL CERTIFICATION



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO. 03267

1. FOR
STATE
REGISTRAR

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. DECEASED NAME (TYPE OR PRINT) Ryda May HADDER | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 13, 1981 | | 2b. HOUR 10 ⁴⁷ A.M. |
| 3. SEX Female | 4. RACE Caucasian | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 25, 1905 | | 6. AGE (IN YEARS LAST BIRTHDAY) 75 YRS. | IF UNDER 1 YEAR MONTHS DAYS |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | 12b. KIND OF BUSINESS OR INDUSTRY Food Service | |
| 13a. STATE Md | | 13b. CITY OR TOWN Ocean City | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS S. Harbor Road. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Edward — Jarvis | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Eva — Taylor | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No — | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS Mrs Alice H. O'Neill, Rt 8, Box 70 Salisbury Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) Umy Cancer
1629
 DUE TO, OR AS A CONSEQUENCE OF
 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
 (b) _____
 DUE TO, OR AS A CONSEQUENCE OF
 (c) _____

APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

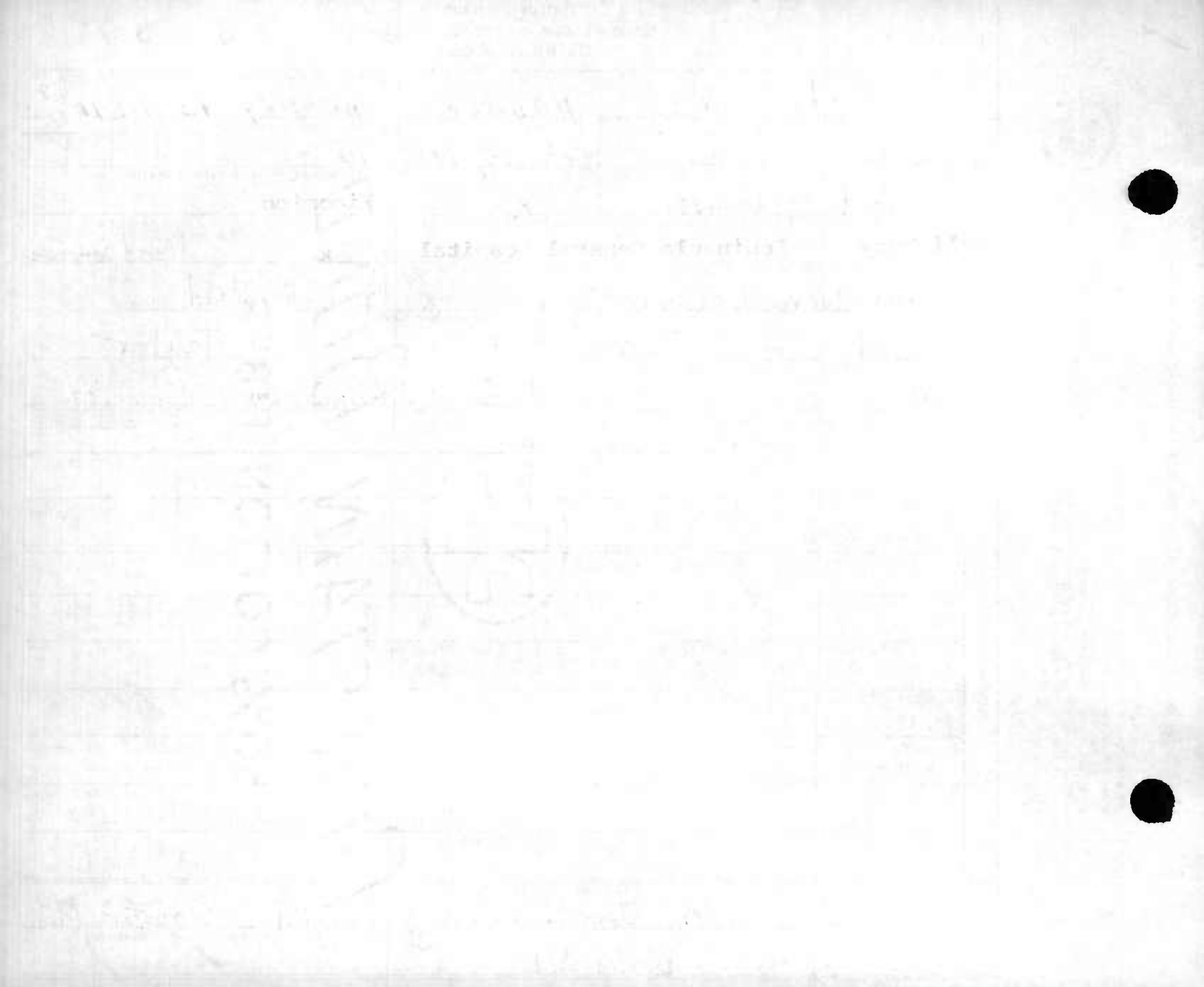
| | | | |
|--|--|--|--|
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (was hospitalized) attended the deceased from <u>12/30</u> , 19 <u>80</u> , to <u>1/13</u> , 19 <u>81</u> , that (I) (was) last saw the deceased alive on <u>1/13</u> , 19 <u>80</u> , and that in (my) (own) opinion death occurred on the date and hour and from the causes stated above. (I) (was) (did) (did not) view the body after death. | | | |
| 22b. SIGNATURE <u>Joseph A. Grasso</u> | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED 1/13/80 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | 22e. ADDRESS 1300 S. Division St Ext. Smis. | |

| | | | |
|--|----------------------|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | 23b. DATE 1/16/81 | 23c. NAME OF CEMETERY OR CREMATORY Sunset Memorial Park | 23d. LOCATION CITY OR TOWN COUNTY STATE Berlin Worcester Md. |
| 24. FUNERAL DIRECTOR NAME Anna A. Burtke | | ADDRESS Berlin, Md. | 25. DATE RECD. BY REGISTRAR JAN 19 1981 |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03268

REG. NO.

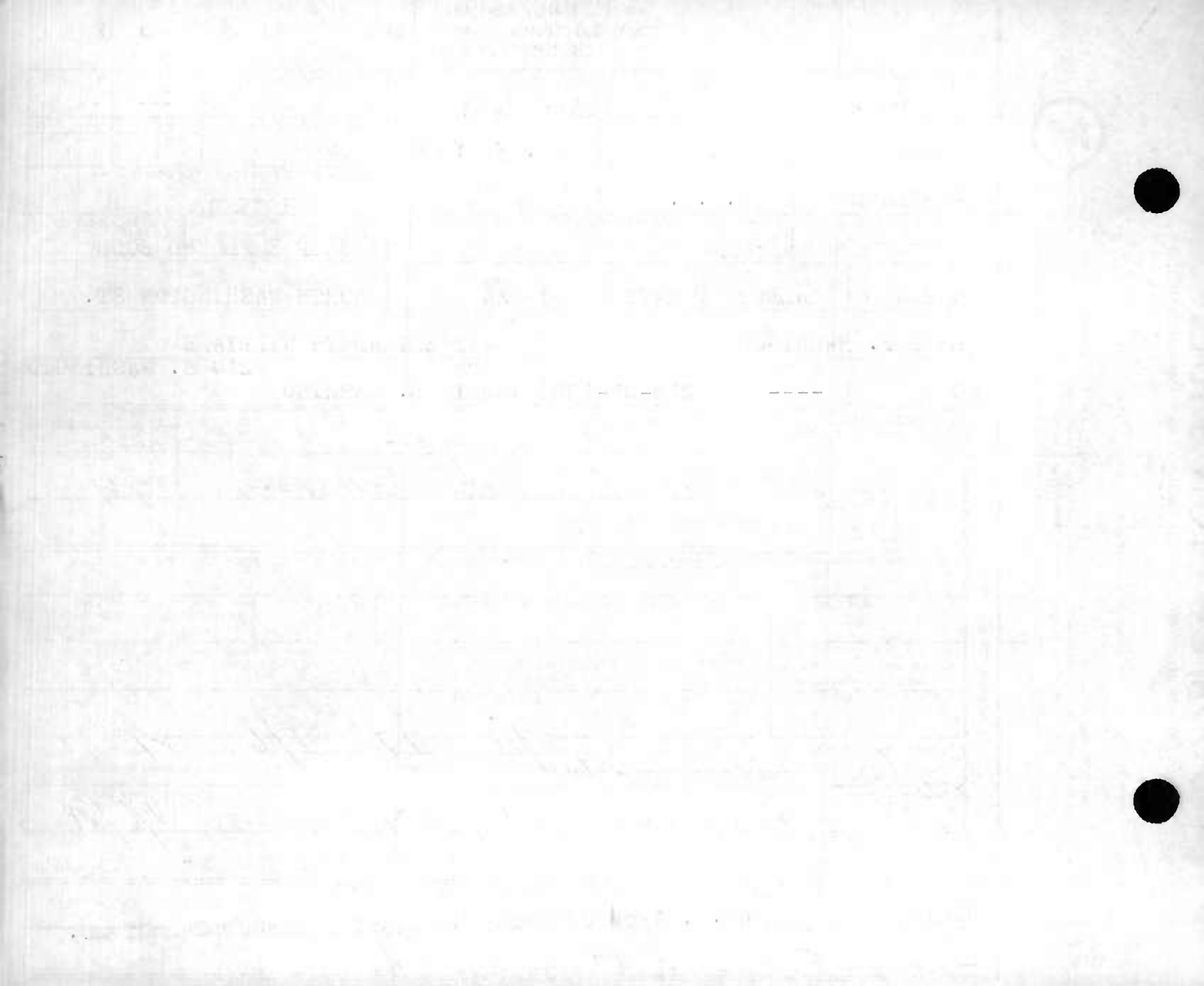
1- FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|---|---|--|---|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Fred S. Harrison | | | 2a. DATE OF DEATH MONTH DAY YEAR 1--06-1981 | | | 2b. HOUR 11:00a | | | |
| 1. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR JAN. 8, 1894 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 10. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) SELF EMPLOYED BOOD | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY TALBOT | | 13c. CITY OR TOWN EASTON | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEVI F. HARRISON | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY ELIZABETH WILLIAMS | | | 13e. STREET ADDRESS NORTH WASHINGTON ST. | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-07-1309 | | 17. INFORMANT NORRIS L. HARRISON | | ADDRESS 214 S. WASHINGTON | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF: (b) generalized atherosclerosis DUE TO, OR AS A CONSEQUENCE OF: (c) hypertension APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 wk. | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS (UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 20d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 20e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 20f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 8/11 19 77 to 1/6 19 81 , that (I) (we) last saw the deceased alive on 1/5 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22a. SIGNATURE Earl M. Beardsley | | | | | | 22b. DEGREE MD | | 22c. DATE SIGNED 1/6/81 | |
| 22d. PHYSICIAN'S NAME (IF DIFFERENT) EARL M. BEARDSLEY, M.D. | | | | | | 22e. ADDRESS US 50 AT CIVIC AVE., SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL SPECIFY BURIAL | | | 23b. DATE JAN. 8, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY SHERWOOD CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY TALBOT MARYLAND | | |
| 24. FUNERAL DIRECTOR NAME Harrison E. Leonard | | | | | | 25. WITNESSED BY REGISTRAR (SEE REGISTRAR'S SIGNATURE) | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 03269 | | | |
|---|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Grace Fern HARSHMAN | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-19-81 | | 2b. HOUR 12:45PM | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 7-28-02 | | 6. AGE (IN YEARS LAST BIRTHDAY) 78 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Springfield, Ill. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Salisbury Nursing Home | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY none | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS 1507 Arbutus Drive | | 14. FATHER'S NAME FIRST MIDDLE LAST Charles Mulvaney | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Margaret Minsin | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 214-10-9599D | | 17. INFORMANT (daughter) RT. 5 Mrs. Betty Kelley, Salisbury, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 1749 IMMEDIATE CAUSE (a) carcinoma of breast - metastasis DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mos. | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/18/81 to 1/19/81 , that (I) (we) lost saw the deceased alive on 1/18/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE DR. EARL M. BEARDSLEY | | | | DEGREE MD | | 22c. DATE SIGNED 1/19/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) DR. EARL M. BEARDSLEY | | | | 22e. ADDRESS RT 50, CIVIC AVE, SALISBURY, M.D | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/21/81 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park, Salisbury, Wic., Md. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | 25b. REGISTRAR'S SIGNATURE Betty Kelley | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03270 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) Simon Harry HEILIG | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 2, 1981 | | 2b. HOUR 12:15 M | | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 14, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 8. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Russia | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Owner | | 12b. KIND OF BUSINESS OR INDUSTRY Provisions Co. | | | |
| 13a. STATE Maryland | | | | | | 13b. COUNTY Worcester | | 13c. CITY OR TOWN Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Faivel Heilig | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Dora (unknown) | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-24-5097 | | 17. INFORMANT (daughter) ADDRESS Mrs. Ruth H. Spinak, Pocomoke City, Md. 344 Winters Quarter | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1536 MASSIVE GASTRIC-INTESTINAL BLEEDING DUE TO, OR AS A CONSEQUENCE OF (b) RENAL & HEPATIC FAILURE DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 hr. | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: CARCINOMA - Right Colon. | | | | | | | | | | | |
| 19a. DATE OF OPERATION 12-22-80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED CARCINOMA - Rt. Colon | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1981 to 2 Jan 1981, that (I) (we) lost the deceased alive on 2 Jan 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE H. Gray Reeves, M.D. | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 2 Jan 1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H. Gray Reeves, M.D. | | | | 22e. ADDRESS Medical Center, Salsbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/4/81 | | 23c. NAME OF CEMETERY OR CREMATORY Beth Israel Cem. | | 23d. LOCATION (CITY OR TOWN) COUNTY STATE Salisbury, Wic., Maryland | | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE L. J. McBratney | | | |

Information

Bellevue Hospital - Psychiatry Department

Admission to Bellevue Hospital
Psychiatric Department

Admission to Bellevue Hospital
Psychiatric Department

Admission to Bellevue Hospital
Psychiatric Department

Admission to Bellevue Hospital
Psychiatric Department

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified (page 3).

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03271 | |
|---|--|---|-------------------------|---|---|--|--|--|--------------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Herman Thomas Hill | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30 1981 | | | 2b. HOUR 12 09 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 20, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Plumbing | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 814 Brown St. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Holland Washington Hill | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Lulia Ethel Figgs. | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) unknown | | 17. INFORMANT ADDRESS Mrs. Mary V. Cox (sister) same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Profound Cardiovascular Collapse</u> 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) <u>Acute Myocardial Infarction</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>A.S.C.V.D.</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH HRS HRS YKS | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (if in this hospital) attended the deceased from <u>1/29</u> , 19 <u>81</u> , to <u>1/30</u> , 19 <u>81</u> , that (we) last saw the deceased alive on <u>1/30</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (We) (and) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Donald M. Wood</u> | | | | DEGREE M ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATED <u>1/30/81</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Donald M. Wood, M.D. | | | | 22e. ADDRESS Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2/1/81 | | 23c. NAME OF CEMETERY OR CREMATORY Melsons Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar, Wic., Maryland | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | ADDRESS 25a. DATE REC'D. BY REGISTRAR FEB 4 1981 | | | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |



Peninsula Community Hospital

San Francisco

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified immediately.

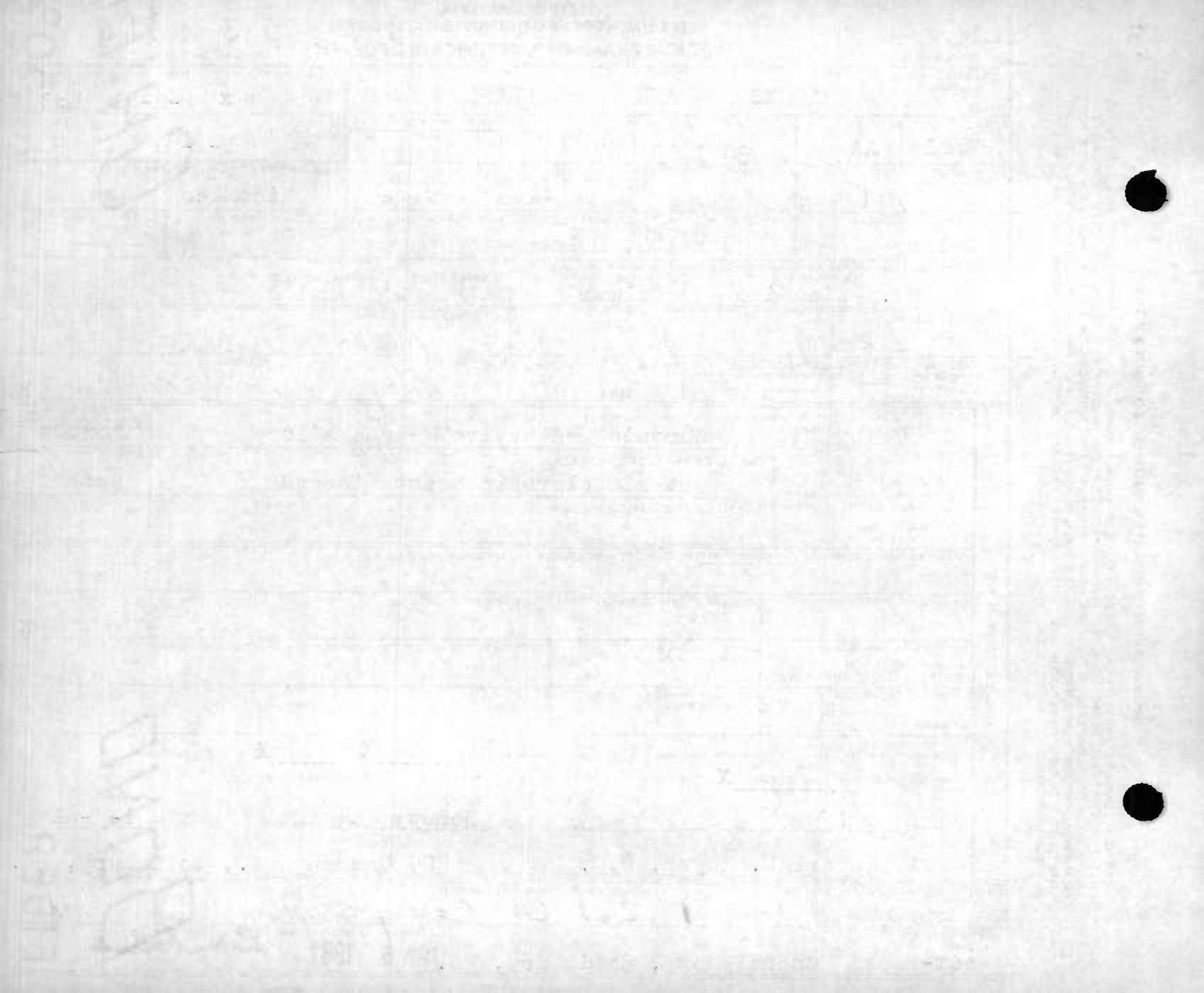
| Item 18a G552 2/17/81 dad | | | | STATE OF MARYLAND | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | 03272 | | | |
|--|--|--|--|--|--|--|--|---|--|--|--|--|--|--|--|
| 1- STATE REGISTRAR | | | | CERTIFICATE OF DEATH | | | | REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | FIRST MIDDLE LAST | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | 2b. HOUR | | | |
| CATHERINE A. HODGSON | | | | | | | | 3 1 11 81 | | | | 12 05 a.m. | | | |
| 3 SEX | | | | 4 RACE | | | | 5. DATE OF BIRTH MONTH DAY YEAR | | | | 6 AGE (IN YEARS LAST BIRTHDAY) | | | |
| FEMALE | | | | W | | | | 3 14 93 | | | | 85 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | | 7b. CITIZEN OF WHAT COUNTRY? | | | | 8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9 BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Bellefonte, Pa. | | | | U.S.A. | | | | | | | | WICOMICO MD. | | | |
| 10 CITY OR TOWN OF DEATH | | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| SALISBURY | | | | SALISBURY NURSING HOME | | | | HOUSEWIFE | | | | none | | | |
| 13a. STATE | | | | 13b. COUNTY | | | | 13c. CITY OR TOWN | | | | 13d. INSIDE CITY LIMITS? | | | |
| MARYLAND | | | | WICOMICO | | | | SALISBURY | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | |
| Archie Allison | | | | Rachel Humes | | | | No | | | | 220-68-8588 | | | |
| 17. INFORMANT ADDRESS | | | | 17. INFORMANT | | | | 17. INFORMANT | | | | 410 South Blvd. Salisbury, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): PART 1 DEATH WAS CAUSED BY: | | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c): | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | |
| 4340 IMMEDIATE CAUSE (a) | | | | Cerebral vascular thrombosis | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | ASCD. | | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | Multiple Myeloma appeared ASCD | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| | | | | 19 | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 19 to 19, that (I) (we) lost saw the deceased above on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | 22b. SIGNATURE DEGREE | | | | 22c. DATE SIGNED | | | | | | | |
| | | | | Joseph C. Fitzgerald M.D. | | | | 1/11/81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | 22f. DATE REC'D. BY REGISTRAR | | | | 22g. REGISTRAR'S SIGNATURE | | | |
| Joseph C. Fitzgerald | | | | Medeal Center Salisbury Maryland 2184 | | | | JAN 14 1981 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | | | 1/13/81 | | | | St. Philips Episcopal Ch. Cem. | | | | Quantico, Wic., Md. | | | |
| 24 FUNERAL DIRECTOR NAME | | | | 24 FUNERAL DIRECTOR ADDRESS | | | | 25. DATE REC'D. BY REGISTRAR | | | | 25. REGISTRAR'S SIGNATURE | | | |
| HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | | | | | | JAN 14 1981 | | | | | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
15M 7/76

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03273 REG. NO. | |
|---|----------------------|--|--|---|--|---|--|--|--|--------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) FRANCES ANN HOLLAND | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-2-81 | | 2b. HOUR 4:30A | |
| 3. SEX Female | 4. RACE AA | 5. DATE OF BIRTH MONTH DAY YEAR 4 30 1893 | 6. AGE (IN YEARS) LAST BIRTHDAY 87 YRS. | IF UNDER 1 YR. MONTHS DAYS 19 | IF UNDER 24 HRS. HOURS MIN 19 | 2c. DATE PRONOUNCED DEAD 1-2-81 | | 2d. HOUR 5 A.M. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Delmar | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Box 184, Delmar | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Box 184 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LEONARD Hopkins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARTHA Hopkins | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. unk | | 17. INFORMANT MARY HARMAN SHARPTOWN md | | ADDRESS | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Chronic Congestive Heart Failure 4140 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Royer | | TITLE (SPECIFY) Deputy MEDICAL EXAMINER | | | | | | DATE SIGNED 1-5-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-10-81 | | 23c. NAME OF CEMETERY OR CREMATORY Zion CH Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Sharptown Wico md | | | |
| 24. FUNERAL DIRECTOR NAME West-Fooks Funeral Home, Salisbury, Md | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | | 25b. REGISTRAR'S SIGNATURE Libby Kelsky | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be filed within 72 hours after death.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03274

FOR
STATE
REGISTRAR

| | | | | | | | | | | |
|--|--|--|---|---|--|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) EMERSON CARROLL HOLLOWAY | | | 2a. DATE OF DEATH MONTH DAY YEAR 11/1/81 | | | 2b. HOUR 11:55 AM | | | | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 4 21 20 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delmar Md | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Councilman | | 12b. KIND OF BUSINESS OR INDUSTRY Wicomico County | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MARYLAND | | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN SALISBURY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 510 Morris Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN WESLEY HOLLOWAY | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LORRAINE BURRIS | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES | | | 16b. SOCIAL SECURITY NO. WWII | | 17. INFORMANT ADDRESS DELORES C. HOLLOWAY SAME AS ABOVE | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CARDIORESPIRATORY ARREST 4029 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Probable Atherosclerotic Cardiovascular Disease (c) HYPERTENSION | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 48 hrs | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) BENIGN INTRACRANIAL HYPERTENSION | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/30 , 19 80 , to 1/1 , 19 81 , that (I) (we) saw the deceased alive on 1/1 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Allen W. Tustin | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 11/1/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Allen W. Tustin | | | 22e. ADDRESS 209 Maryland Ave., Salisbury, MD 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1-5-81 | | 23c. NAME OF CEMETERY OR CREMATORY SPRINGHILL MEM. GDNS | | 23d. LOCATION CITY OR TOWN COUNTY STATE HEBRON WICOMICO MD | | | |
| 24. FUNERAL DIRECTOR NAME Jolley's Memorial Chapel | | | ADDRESS Bt. 2 Jersey Rd Salisbury, Md | | 25a. DATE REC'D BY REGISTRAR JAN 9 1981 | | 25b. SIGNATURE [Signature] | | | |

BP _____



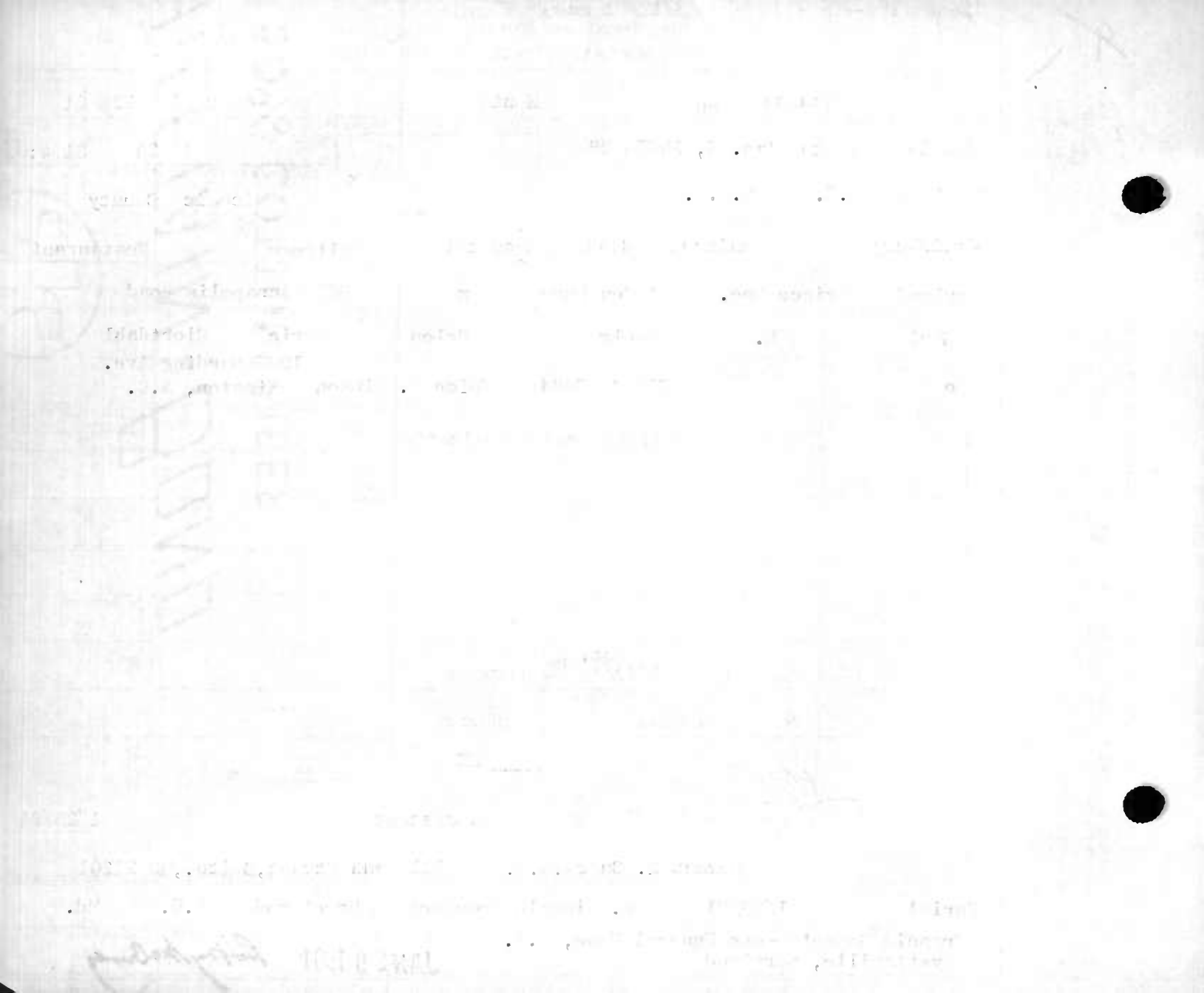
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03275

| | | | | | | | | | | | | | | | | | |
|--|---------|---|--|--|--|---|--|-------------------------|--|--------------------------|--|-------|--|------|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF DEATH | | MONTH | | DAY | | YEAR | | 2b. HOUR | |
| Denise Ann Honig | | | | | | | | 1 | | 23 | | 19 | | 81 | | 4:05 AM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS) | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | |
| female | white | Jan. 6, 1953 | | 28 | | | | | | 1 | | 24 | | 19 | | 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | |
| Washington D.C. | | U.S.A. | | | | Wicomico County | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | |
| Salisbury | | Peninsula General Hospital | | Waitress | | Restaurant | | | | | | | | | | | |
| 13a. STATE | | 13b. CITY OR TOWN | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | | | | | | | | | |
| Maryland | | Prince Geo. | | Bladensburg | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 5800 Annapolis Road | | | | | | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| Earl L. Honig | | Helen Marie Hiortdahl | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | | | | | | | | | | | |
| No | | 530 48 5884 | | Helen M. Hinson | | Kinston, N.C. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: 9805 IMMEDIATE CAUSE (a) Multiple drug intoxication DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | 20. AUTOPSY? | | | | | | | | | | | | | |
| | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| | | Est. 1/23/81 | | unknown | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION | | | | | | | | | | | | | |
| | | Unknown | | Unknown | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on death resulted from: <input checked="" type="checkbox"/> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input checked="" type="checkbox"/> Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion | | | | | | | | | | | | | | | | | |
| 22b. TITLE (SPECIFY) Assistant MEDICAL EXAMINER DATE SIGNED 1/25/81 | | | | | | | | | | | | | | | | | |
| 22c. ACTUAL SIGNATURE [Signature] M.D. Hormez R. Guard, M.D. ADDRESS 111 Penn Street, Balto., MD 21201 | | | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | | | | | | | | | | | |
| Burial | | 1/28/81 | | Ft. Lincoln Cemetery | | Brentwood | | P.G. | | Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Francis Gasch's Sons Funeral Home, P.A. Hyattsville, Maryland | | | | | | | | | | | | | | | | | |
| 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE [Signature] JAN 29 1981 | | | | | | | | | | | | | | | | | |

DIVISION OF VITAL RECORDS, 201 W. PRESTON ST., BALTIMORE, MD. 21201

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM-3. RETAIN PAGE 5 FOR VITAL FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP

DHMH - 17
(VR A15 ME (1))
15M 2/80

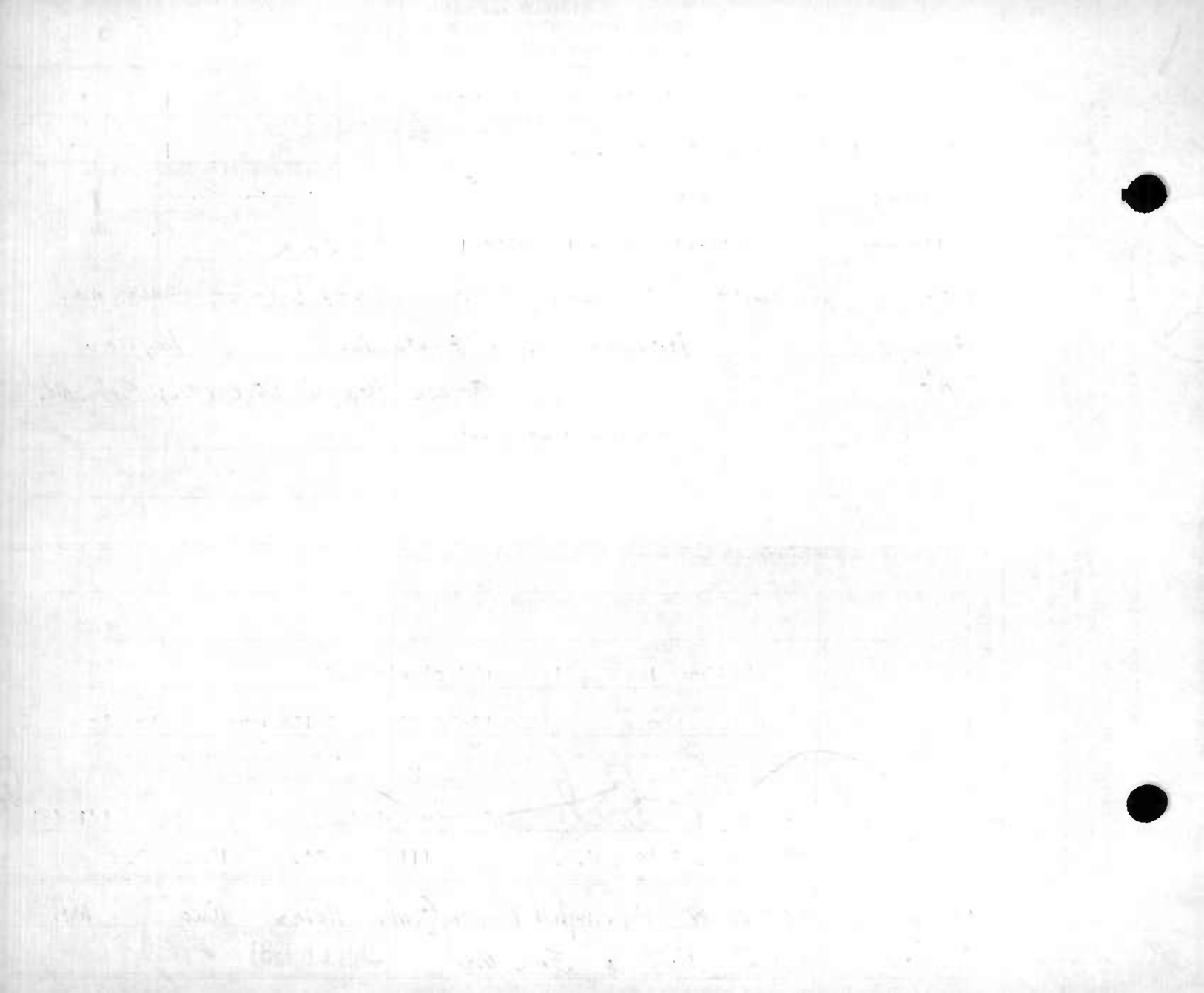
STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

03276

REG. NO.

1- FOR
STATE
REGISTRAR

| | | | | | | | | |
|--|------------------|--|---|---|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Johnny Louis Howard | | | 2a. DATE KNOWN OF DEATH ESTIMATED 1 9 1981 | | | 2b. HOUR a 4:30 | | |
| 3. SEX Male | 4. RACE Black | 5. DATE OF BIRTH MONTH DAY YEAR 1-25-58 | 6. AGE (IN YEARS) (LAST BIRTHDAY) 22 YRS. | IF UNDER 1 YR. MONTHS DAYS HOURS MIN. | IF UNDER 24 HRS. | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1 9 19 81 | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD. | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Cook | | 12b. KIND OF BUSINESS OR INDUSTRY |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | 13a. STATE Md. | | | 13b. COUNTY Wicomico | | |
| 13c. CITY OR TOWN Salisbury | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS 624 Light St. Salis. md. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Howard Sr. | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Geetude Leggins | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | |
| 16b. SOCIAL SECURITY NO. | | | 17. INFORMANT George Howard P.O. Box 1266 Salis. Md. | | | ADDRESS | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stab wound of chest 9660 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 3:45 PM 1 9 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) subject stabbed | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) home | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 624 Light St. Salisbury Wicomico MD | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith, M.D. | | | TITLE (SPECIFY) M.D. Deputy Chief | | | DATE SIGNED 1/10/81 | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | ADDRESS 111 Penn St. Balto., MD. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE IF Y) Burial | | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Garden | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wico Md. | |
| 24. FUNERAL DIRECTOR NAME Clinton F. Stewart | | | ADDRESS West Rd. Salis. Md. | | | 25b. DATE REC'D. BY REGISTRAR JAN 16 1981 | | |
| | | | | | | 25a. REGISTRAR'S SIGNATURE [Signature] | | |





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP

DHMH-16 30M 2/80
(VRA 15, 4)

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03277

| | | | | | | | |
|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | January 9 1981 | | 10 15/4 M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| Female | | White | | August 3, 1900 | | 80 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| Covington, Ky. | | U.S.A. | | | | Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | Peninsula General Hospital | | DuPont Nylon Plant | | in Seaford | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 13b. STATE | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | |
| Maryland | | Wicomico | | Salisbury | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | 13e. STREET ADDRESS | | | |
| FIRST MIDDLE LAST | | FIRST MIDDLE LAST | | Pine Bluff Village, Apt. 112 | | | |
| Paul B. Reynolds | | Sadie Bell | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | |
| No | | 218-20-4149 | | Mrs. Betty R. Gouge, Rt. 8, Box 45, Md. | | Salisbury, | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | PART I. DEATH WAS CAUSED BY: | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| IMMEDIATE CAUSE (a) | | Congestive Heart Failure and Pneumonia | | 4 days | | | |
| 4280 | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | (b) | | | | | |
| | | DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| | | (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY | | 21c. HOW INJURY OCCURRED | | (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | HOUR A.M. MONTH DAY YEAR | | | | | |
| | | P.M. 19 | | | | | |
| 21d. INJURY OCCURRED | | 21e. PLACE OF INJURY | | 21f. LOCATION | | | |
| WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | CITY OR TOWN | | COUNTY STATE | |
| | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/3 1981 to 1/9 1981, that (I) (we) lost saw the deceased alive on 1/9 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | 22c. DATE SIGNED | | | |
| S A Abrams | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | |
| | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION | |
| Burial | | Jan. 11, 1981 | | Cokesbury Cemetery | | Cokesbury, Dorchester, Md. | |
| 24. FUNERAL DIRECTOR | | 25a. DATE RECEIVED BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| NAME ADDRESS | | JAN 13 1981 | | | | | |
| Frampton Hawkins Funeral Home, 216 N. Main St. | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03278

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|--|--|---|------------------------------|---|---|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST <i>Theresa M. Jenkins</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 22, 1981</i> | | 2b. HOUR <i>1:35 A.M.</i> | | |
| 3. SEX <i>Female</i> | | 4. RACE <i>White</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>9-5-84</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS HOURS MIN. <i>96</i> | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Virginia</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD. | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i> | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>Housewife</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>Own Home</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE 13b. COUNTY 13c. CITY OR TOWN <i>Maryland Worcester Snow Hill</i> | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>205 E. Market St.</i> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>William Brew</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Sallie Bailey</i> | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) <i>No</i> | | | | 16b. SOCIAL SECURITY NO. <i>None</i> | | 17. INFORMANT ADDRESS <i>Hattie A. Spencer, Snow Hill, Md.</i> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory Arrest</i> <i>4140</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Advanced Age</i> | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) lost saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Chayton L. Raab</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <i>1-22-80</i> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>Chayton L. Raab M.D.</i> | | | | 22e. ADDRESS <i>Locust & Quincy St's Salisbury, Md.</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (TYPE) <i>Burial</i> | | 23b. DATE <i>1-24-81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Mt. Holly</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Chancock Virginia</i> | |
| 24. FUNERAL DIRECTOR NAME <i>Norman F. Dennis</i> | | | | ADDRESS <i>Snow Hill, Md.</i> | | 25a. DATE RECORDED BY REGISTRAR <i>JAN 27 1981</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |

MEDICAL CERTIFICATION

A

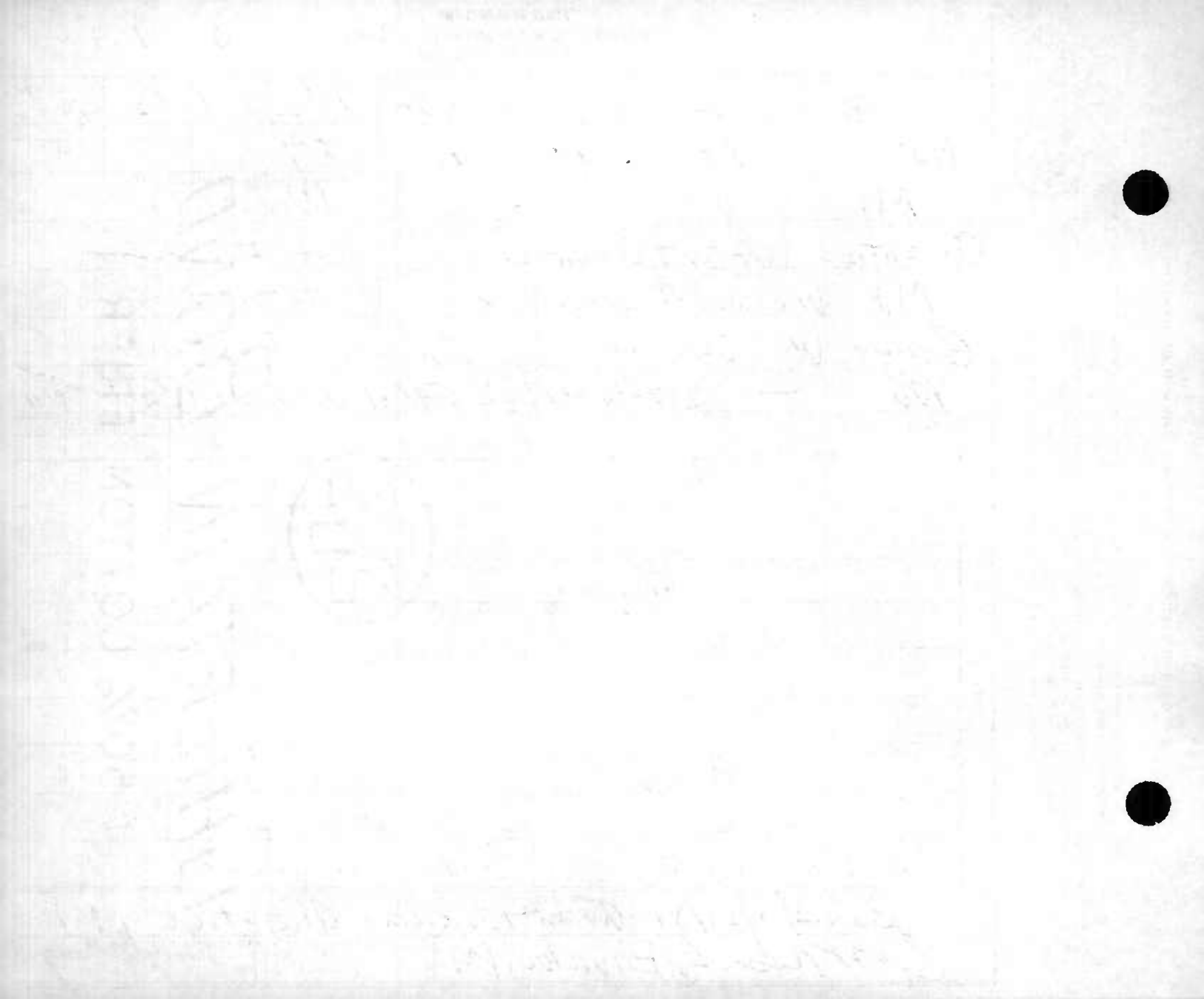
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after the death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of cause.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03279 | | | |
|--|--|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) ROLAND B. JOHNSON, Jr | | | | | 2a. DATE OF DEATH MONTH 1 DAY 22 YEAR 1981 | | | | 2b. HOUR 4:40 P M | | | | |
| 3. SEX Male | | 4. RACE AA. | | 5. DATE OF BIRTH MONTH 1 DAY 4 YEAR 194 | | 6. AGE (IN YEARS LAST BIRTHDAY) 67 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Quantico | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RT 347 Quantico | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. STATE MD | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Quantico | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS RT 347 | | | | | |
| 14. FATHER'S NAME FIRST George W. MIDDLE LAST Johnson | | | | | 15. MOTHER'S MAIDEN NAME FIRST Emma MIDDLE LAST Fortune | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-14-4508 | | 17. INFORMANT ADDRESS Ethel Dashiell, Baltimore | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cancer of Prostate G 1850 DUE TO, OR AS A CONSEQUENCE OF (b) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Emphysema | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (a) (this hospital) attended the deceased from Feb , 19 75 , to 1-22 , 19 81 , that (b) (we) lost saw the deceased alive on 12/25 , 19 80 , and that in (c) (our) opinion death occurred on the date and hour and from the causes stated above. (b) (we) did (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE C. R. Layton Jr | | | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1-24-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) C. R. Layton Jr | | | | | 22e. ADDRESS P.O. Box 21801 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried | | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY Quantico Cem. | | | 23d. LOCATION CITY OR TOWN Quantico COUNTY MD STATE | | | | | |
| 24. FUNERAL DIRECTOR Compassionate Burial Co, Baltimore, MD | | | | | 25a. DATE REC'D. BY REGISTRAR 1-28-81 | | 25b. REGISTRAR'S SIGNATURE Harry H. Bundy | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 must be retained by the hospital or attending physician.

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1- FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03280

| | | | | | |
|--|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOSEPHINE Lillian Jones | | | 2a. DATE OF DEATH MONTH DAY YEAR January 4, 1981 | | 2b. HOUR 5:29 PM |
| 3. SEX FEMALE | 4. RACE WHITE | 5. DATE OF BIRTH MONTH DAY YEAR SEPT. 16, 1904 | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MINNESOTA | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE COUNTY DELAWARE SUSSEX | | 13c. CITY OR TOWN DELMAR | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JOHN Anthony Doman | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST MARY BIN Koski | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-07-6098 | 17. INFORMANT ADDRESS ERNEST JONES St Lukes Rd FRUITLAND, Md. | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral thrombosis 4340 DUE TO, OR AS A CONSEQUENCE OF (b) Hypertension DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1100 |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). Unwed | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 12-24 1980 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-24 1980 to 1-4 1981 , that (I) (we) last saw the deceased alive on 1-4 1981 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE William R. Ellis Jr. | | DEGREE MD | | 22c. DATE SIGNED 1-4-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Wilbur R. Ellis Jr. | | 22e. ADDRESS Ray Dr. Salisbury Md | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE 1/7/1981 | 23c. NAME OF CEMETERY OR CREMATORY Springhill Memory Gardens | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Md | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | ADDRESS Salisbury Md | | 25a. JAN 8 BY REG 1501 25b. REGISTRAR'S SIGNATURE | |

BP

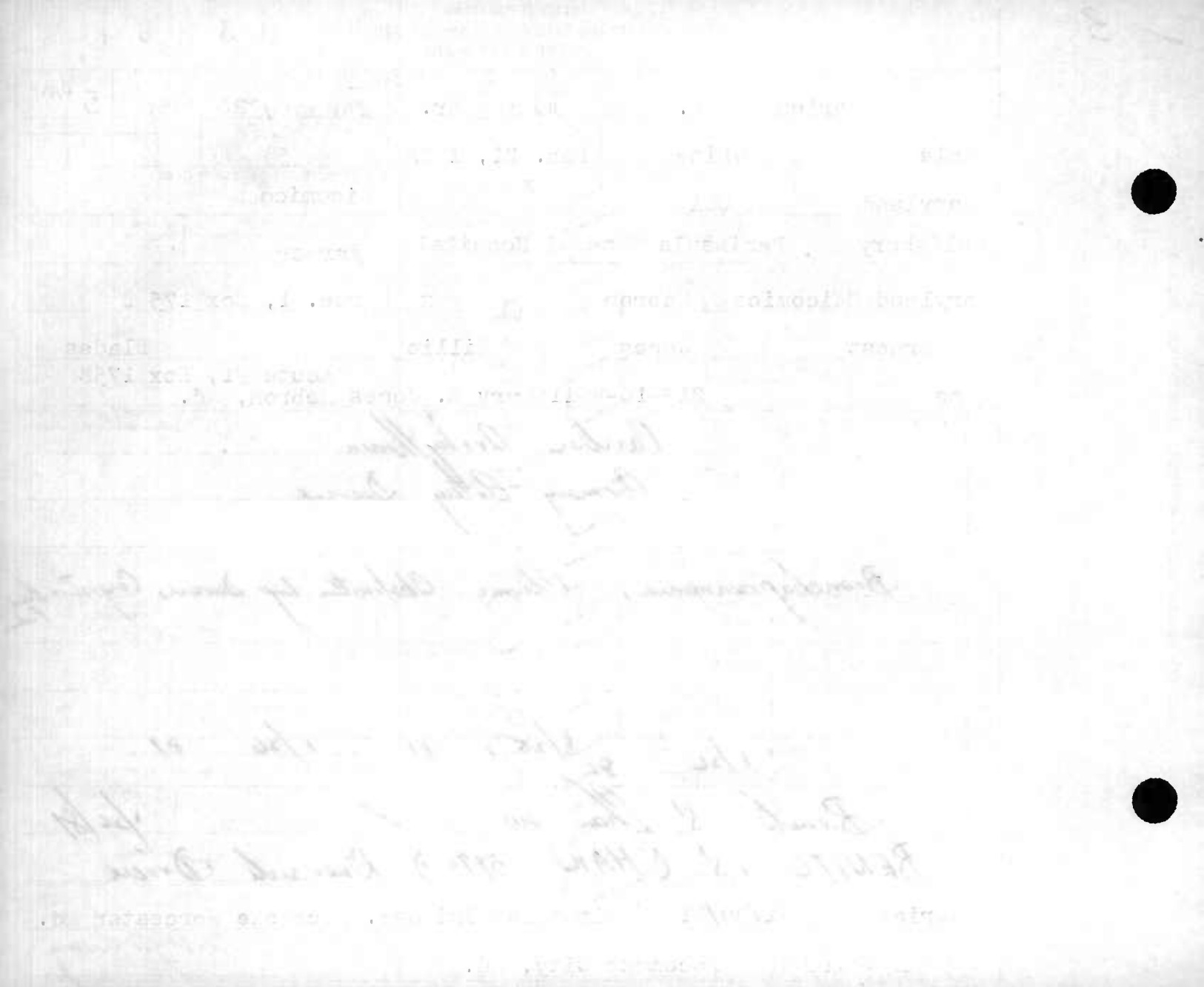
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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of this.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03281 | |
|---|--|---|--|---|--|---|--|--|---|--|--|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Marion M. Jones Sr. | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 26, 1981 | | | 2b. HOUR 5 PM | | |
| 3. SEX male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 21, 1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS | | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Hebron | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS rte. 1, Box 175 B | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest Jones | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Willie Blades | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 215-18-4911 | | 17. INFORMANT ADDRESS// Route #1, Box 175B Mary E. Jones Hebron, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac Arrhythmia</u> 4449 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Primary Artery Disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Bronchopneumonia, Chronic Obstructive Lung Disease, Congestive Heart Failure</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/25</u> , 19 <u>81</u> , to <u>1/26</u> , 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1/26</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Benito S. Chan</u> | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/26/81</u> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>BENITO S. CHAN</u> | | | | 22e. ADDRESS <u>547-D Riverside Drive</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY First Baptist Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Worcester Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Scott S. Nelson</u> | | | | ADDRESS Pocomoke City, Md. | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03282

REG. NO.

| | | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) NATHAN LOUIS KARWELL | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-29-81 | | | 2b. HOUR 3:57A.M. | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 12 15 15 | | 6. AGE (IN YEARS LAST BIRTHDAY) 65 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) New York | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) STORE OWNER RET | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Md. | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 108 W. Isabella St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST HERMAN KARP | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CELIA GOLDIN | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | 16b. SOCIAL SECURITY NO. 109-09-0990 | | 17. INFORMANT ADDRESS Lucy C. Karwell, Same as 13c | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Adenocarcinoma 1519 DUE TO, OR AS A CONSEQUENCE OF (b) Carcinoma of Stomach Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH months months | | | | | | | | PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 1-16-81 , 19____, to 1-29-81 , 19____, that (I) (we) last saw the deceased alive on 1-28-81 , 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22a. SIGNATURE Earl L. Royer, M.D. | | | | | DEGREE MD | | | 22c. DATE SIGNED 1-29-81 | | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) CREMATION | | | 23b. DATE 1/29/1981 | | 23c. NAME OF CEMETERY OR CREMATORY DELMARVA CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE LOWES SUSSEX DE | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Md. | | | | | 25a. DATE RECD. BY REGISTRAR FEB 2 1981 | | | | | |
| 25b. REGISTRAR'S SIGNATURE | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, each page should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| 1. FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03283 | | | |
|---|--|--|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) CLARENCE Z KELLER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 6 81 | | | | 2b. HOUR 2¹⁰ PM | | | |
| 3 SEX MALE | | 4 RACE CAU. | | 5 DATE OF BIRTH MONTH DAY YEAR APRIL 12, 1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | 7a. IF UNDER 1 YEAR MONTHS DAYS | | 7b. IF UNDER 24 HRS. HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Pennsylvania | | 9a. CITIZEN OF WHAT COUNTRY? U. S. A. | | 9b. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9c. BALTIMORE CITY OR COUNTY OF DEATH Nicomico MD. | | | | | |
| 10 CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Horticulture | | 12b. KIND OF BUSINESS OR INDUSTRY Farming | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. COUNTY Maryland Somerset | | | | 13d. CITY OR TOWN SALISBURY | | 13e. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13f. STREET ADDRESS Cambridge, Md. 21613 | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Oliver Will Keller | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Annie Kate Zeigler | | | | | | | |
| 16a. WAS DECEASED EVER IN U. S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 216-38-9146 | | 17 INFORMANT wife ADDRESS Cambridge, Md. 21613 Mrs. Louise H. Keller, Oakley Terrace Apts. | | | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebro Vascular Accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) Carcinoma of prostate APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 9-17-79 19 81 , to 1-6 19 81 , that (I) (we) lost saw the deceased alive on 12-31 19 81 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (Type) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE A. C. Mitchell | | | | DEGREE MD | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 7 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A. C. Mitchell MD | | | | 22e. ADDRESS POB 2378 Salisbury, Md | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) burial | | | | 23b. DATE Jan. 9, 1981 | | 23c. NAME OF CEMETERY Christ Episcopal Ch. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Cambridge, Dorchester, Md. | | | |
| 24 FUNERAL DIRECTOR NAME Curran Funeral Home | | | | ADDRESS 308 High St., Cambridge | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

U.S. 100

UNITED STATES

Check No. 100-100

DATE: 10-10-10

Pay to the order of

Payable to the order of

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For the Treasurer of the
County of ... State of ...
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03284 | |
|---|--|---|--|--|--|---|---|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Franklin James Kelly | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 21, 1981 | | | 2b. HOUR 11:15 A.M. | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR May 17, 1893 | | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Agriculture | | | |
| 13a. STATE Md. | | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Powellville | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William - Kelly | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bell - Polk | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 219-05-8913A | | 17. INFORMANT Mrs. Edith M. Donovan | | | | ADDRESS Powellville, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Carcinoma of Prostate DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Urinary tract infection - Atherosclerotic Cardiovascular Disease | | | | | | | | | | | |
| 19a. DATE OF OPERATION Jan 14 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Prostatectomy | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Jan 14 , 19 81 , to Jan 21 , 19 81 , that (I) (we) last saw the deceased alive on Jan 20 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Thomas C. Hill Jr. M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/21/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR | | | | | | 22e. ADDRESS Pine Bluff Road, Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/24/81 | | 23c. NAME OF CEMETERY OR CREMATORY St. John's Cemetery | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Powellville Wicomico Md. | | | |
| 24. FUNERAL DIRECTOR NAME Anna A. Bubeck | | | | | | ADDRESS Berlin, Md. | | 25a. DATE REC'D BY REGISTRAR JAN 27 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03285

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | |
|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Carrie E. LAMBERT | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 28 1981 | | | 2b. HOUR 9:30 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JULY 21, 1907 | | 6. AGE (IN YEARS LAST BIRTHDAY) 73 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Oxford, N. Y. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | |
| 13a. STATE N. Y. | | 13b. COUNTY Onondaga | | 13c. CITY OR TOWN Syracuse | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 13e. STREET ADDRESS Box 94 | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST (unknown) | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST (unknown) | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 070-52-2087 | | 17. INFORMANT (son) ADDRESS Box 496, Rt. 8 Mr. Melvin Lambert, Salisbury, Md. | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a) *Respiratory arrest*

4140
Conditions, if any, which
gave rise to immediate
cause (a), stating the
underlying cause last.

DUE TO, OR AS A CONSEQUENCE OF

(b) *Recent resuscitation from cardiac arrest*

DUE TO, OR AS A CONSEQUENCE OF

(c) *Atherosclerotic heart disease*APPROXIMATE INTERVAL
BETWEEN ONSET AND DEATH

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a).

MEDICAL CERTIFICATION

| | | | | | | | |
|---|--|--|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from <u>1/22/81</u> , 19 <u>81</u> , to <u>1/28/81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/24/81</u> , 19 <u>81</u> , and that in my (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE <i>Clayton L. Raab</i> | | | | DEGREE | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton L. Raab M.D. | | | | 22e. ADDRESS Loomis & Quincy St's Salisbury Md 21801 | | | |

| | | | | | | | |
|--|--|---------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY Crown Hill Memorial Park Kirkland, Madison, N.Y. | | 23d. LOCATION CITY OR TOWN COUNTY STATE | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Maryland | | | | 25a. DATE REC'D. BY REGISTRAR 25b. REGISTRAR'S SIGNATURE FEB 2 1981 | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

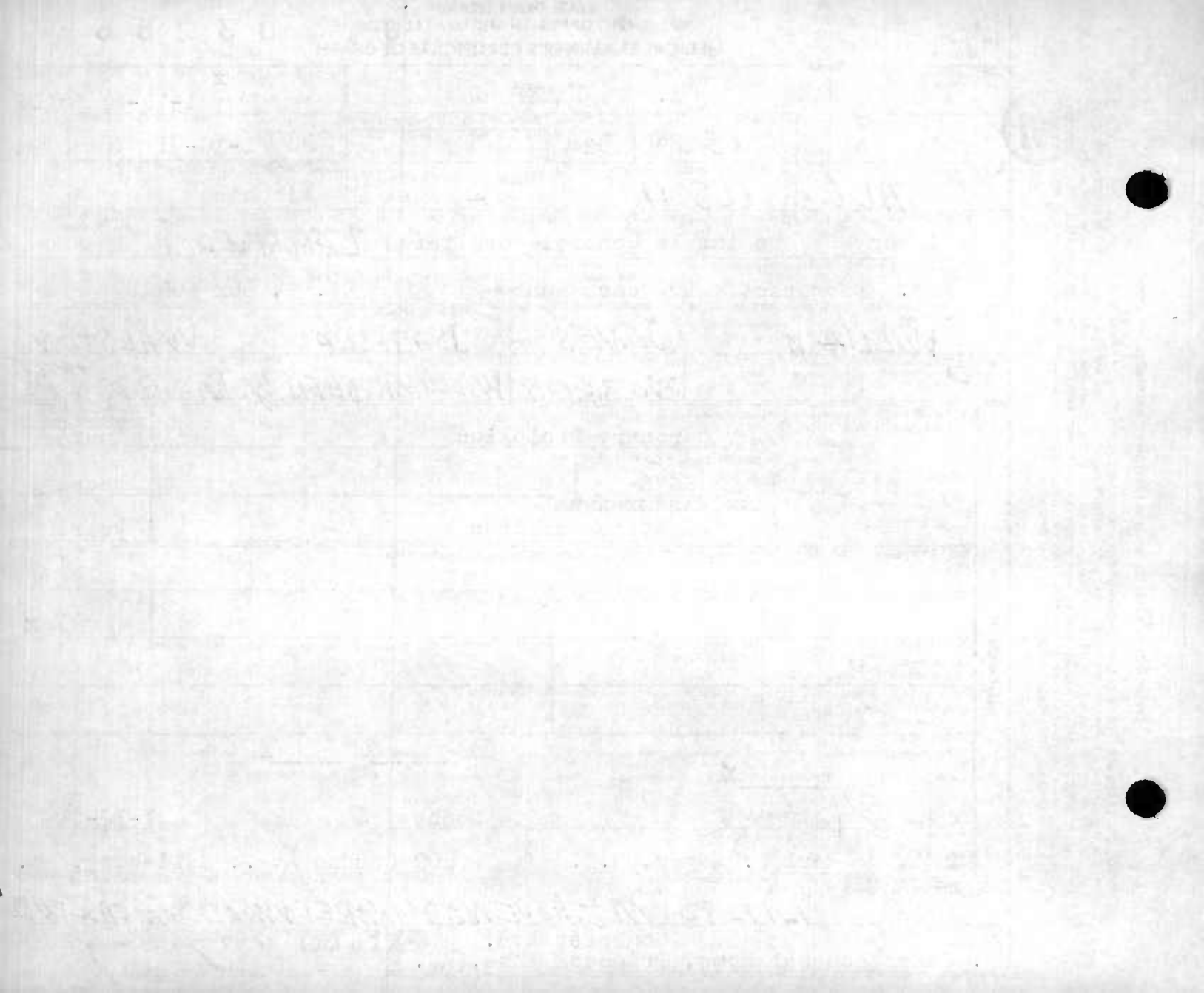
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Library of Congress

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| 1- STATE REGISTRAR | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | 03286 REG. NO. | | | |
|---|--|--|--|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) NANCY A. LANKFORD | | | | | | 2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> MONTH DAY YEAR 1-10-81 2b. HOUR 5:40P | | | |
| SEX Female | | 4. RACE AA | | 5. DATE OF BIRTH MONTH DAY YEAR 9 02 1898 | | 6. AGE (IN YEARS) LAST BIRTHDAY 82 YRS. | | 7. IF UNDER 1 YR. IF UNDER 24 HRS. | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) md | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MD. | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Princess Anne | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Rt. 3, Box 504 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILLIAM JONES | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ISABELLA WALSTON | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES/NO OR UNKNOWN) 0 | | | | 16b. SOCIAL SECURITY NO. 22C 3-4318 | | 17. INFORMANT ADDRESS WILLIAM KEELING, Rt 3-Box 504, Pr. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 4100 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) ASCVD (c) Diabetes Mellitus | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | |
| ACTUAL SIGNATURE [Signature] | | | | TITLE (SPECIFY) Deputy M.D. MEDICAL EXAMINER | | | | DATE SIGNED 1-12-81 | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) 1-17-80 | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY MT HOPE MT Zion GREENWOOD | | 23d. LOCATION CITY OR TOWN COUNTY STATE SOMERSET MD. | | | |
| 24. FUNERAL DIRECTOR NAME Wm. James Funeral Home, ADDRESS Somerset Ave. | | | | 25. DATE READY BY REGISTRAR JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |



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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

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DHMH - 16 50M 7/77
(VRA 15 (4))

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | | |
|--|--|---|--|---|--|--|--|---|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Gus J. Lavezzo | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 13, 1981 | | | 2b. HOUR 10⁵⁰ P.M. | | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR JUNE 11, 1926 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 54 | | | IF UNDER 1 YEAR IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) WASH D.C. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) OWNER | | | 12b. KIND OF BUSINESS OR INDUSTRY Service Station | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE DELAWARE 13b. COUNTY SUSSEX 13c. CITY OR TOWN OCEAN VIEW | | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | 13e. STREET ADDRESS P.O. Box 254 Central Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANK J. LAVEZZO | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CATHERINE - LAGAMARSINO | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) YES (IF YES, GIVE WAR OR DATES) WW II | | | | 16b. SOCIAL SECURITY NO. 579-24-7610 | | 17. INFORMANT WIFE ADDRESS SAME AS # 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 4254 IMMEDIATE CAUSE (a) Congestive Heart Failure / Arrhythmias DUE TO, OR AS A CONSEQUENCE OF (b) Cardiomyopathy DUE TO, OR AS A CONSEQUENCE OF (c) Renal Stone - Part of | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8/1/81 to 1/13/81 , that (I) (we) lost saw the deceased alive on 1/13/81 , and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | 22c. DATE SIGNED | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Oswald J. Burton, MD | | | | 22e. ADDRESS Kay Ave. Salisbury Maryland 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/17/81 | | 23c. NAME OF CEMETERY OR CREMATORY GATE OF HEAVEN CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE SILVER SPRING Md. | | | |
| 24. FUNERAL DIRECTOR NAME John F. DeVol | | | | ADDRESS WASH. D.C. | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Anthony McCreedy</i> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonappers: Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal. IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

10

1. FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03288

| | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--------------------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) Cowell Colwell W. LAYFIELD | | | 2a. DATE OF DEATH MONTH DAY 1981 JANUARY 22, 1981 | | | 2b. HOUR 9⁰⁵ AM | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 1, 1892 | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS 88 1 21 | | 7b. HOUR 9⁰⁵ AM | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. #3 | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST James Robert Layfield | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Phoebe Jane Hastings | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 214-12-6956 | | 17. INFORMANT ADDRESS Alice Mae Mitchell Layfield Delmar, De | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cardiop. anest 4960 DUE TO, OR AS A CONSEQUENCE OF (b) chronic obst. pulmonary disease DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): senility, cancer skin, congestive Heart Failure | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from Feb , 19 79 , to 12/12 , 19 80 , that (I) (we) lost saw the deceased alive on 12/12 , 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE Saggan MD | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1. 22. 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) D. SAGGAR | | | 22e. ADDRESS 547-E Riverside Drive Salisbury | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1-25-81 | | 23c. NAME OF CEMETERY OR CREMATORY Melsons Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar, Wicomico Maryland | | | |
| 24. FUNERAL DIRECTOR NAME William M. Short Marvel-Short Funeral Home Delmar, De. | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Anthony McCreedy | | | |

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2022-01-10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03289 | |
|---|--|--|--|---|---|--|---|---|--|----------|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) WILLIAM HOWARD LIVINGSTONE | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 30 - 1981 | | | 2b. HOUR 12 47 P.M. | | | |
| 3. SEX M | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 26, 1921 | | 6. AGE (IN YEARS LAST BIRTHDAY) 60 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Accountant | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 312 Washington Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Clarence Livingston | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Henrietta Mumford | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | | 16b. SOCIAL SECURITY NO. WW II 215-12-6645 | | 17. INFORMANT ADDRESS same as 13 Mrs. Elizabeth A. Livingstone (wife) | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) G MAN NEGATIVE SEPSIS 5621 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: (b) DIVERTICULITIS COLON DUE TO, OR AS A CONSEQUENCE OF (c) DEATH SCENE WOUND | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 36 HRS 4 YRS 3 DAYS | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION 1-22-81 1-6-81 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 18B | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1-1 , 19 79 , to 1-30 , 19 81 , that (I) (we) last saw the deceased alive on 1-30 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE John M. Bloxom III | | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1-30-1981 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOAN M. BLOXOM III | | | | | 22e. ADDRESS MEDICAL CENT. SALISBURY, MD. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 2/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY Wicomico Mem. Park | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 4 1981 | | 25b. REGISTRAR'S SIGNATURE P. J. H. H. H. | | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03290 | | | | |
|--|--|--|---|--|---|--|--|--|---------------------------------------|--|-----------------------------------|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARY --- MacIntosh | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 9 1981 | | | | | 2b. HOUR 5:50 PM | | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 3 12 98 | | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Montclair N.J. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Md. 13b. COUNTY P.G. | | | | | 13c. CITY OR TOWN Greenbelt | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 47 Lakeside Dr | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Jeremiah - Joyce | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary -- Lenihan | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 084-09-7950 | | 17. INFORMANT ADDRESS Mr. Harry MacIntosh 35 Riveredge Rd; (N.J) Fairfield | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Respiratory Failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Staph. Pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>chronic obstructive pulmonary disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>Jan 1, 1981</u> , to <u>Jan 9, 1981</u> , that (I) (we) last saw the deceased alive on <u>1. 9. 1981</u> , and that in <u>my</u> (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>Dr. Deepak Saggard</u> | | | | DEGREE <u>MD</u> | | | | 22c. DATE SIGNED <u>1. 9. 1981</u> | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Dr. Deepak Saggard MD</u> | | | | 22e. ADDRESS <u>541 Riverside Dr., Salisbury, Md.</u> | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY Immaculate Conception | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Montclair Essex N.J. | | | | |
| 24. FUNERAL DIRECTOR NAME <u>Holloway Funeral Home P.A. Salisbury</u> | | | | ADDRESS MD. | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE <u>Robert M. B...</u> | | | | | | |

Washington, D.C. 20540

1981 JAN 1

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03291

FOR
STATE
REGISTRAR

| | | | | | | | |
|--|--|--|---|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) <u>William A. Maddox</u> | | | 2a. DATE OF DEATH MONTH <u>January</u> DAY <u>19</u> YEAR <u>1981</u> | | | 2b. HOUR <u>9:30</u> P.M. | |
| 3. SEX <u>M</u> | | 4. RACE <u>AA</u> | | 5. DATE OF BIRTH MONTH <u>9</u> DAY <u>21</u> YEAR <u>1909</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>71</u> YRS. MONTHS <u>0</u> DAYS <u>0</u> HOURS <u>0</u> MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD. | |
| 10. CITY OR TOWN OF DEATH <u>Salisbury</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>Seafarer</u> | |
| 12b. KIND OF BUSINESS OR INDUSTRY <u>—</u> | | | | | | | |

| | | | | | | | | | | | |
|---|--|--|---|--|----------------------------------|---|--|--|------------------------------------|--|--|
| 13a. STATE <u>Mt</u> | | | 13b. COUNTY <u>Wicomico</u> | | 13c. CITY OR TOWN <u>Tyaskin</u> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <u>Box 152</u> | | |
| 14. FATHER'S NAME FIRST <u>William A.</u> MIDDLE <u>M.</u> LAST <u>Maddox</u> | | | 15. MOTHER'S MAIDEN NAME FIRST <u>Sadie</u> MIDDLE <u>Nichols</u> LAST <u>Tyaskin</u> | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>YES</u> | | | 16b. SOCIAL SECURITY NO. <u>1NW 11 217-09-5301</u> | | | 17. INFORMANT <u>Henrietta Maddox, Tyaskin Mt</u> | | | ADDRESS | | |

| | | | |
|--|--|--|--|
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: <u>1509 Esophageal Cancer</u> | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) <u>Esophageal Cancer</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) <u>—</u> | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) <u>—</u> | | | |

PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

| | | | | | | | |
|--|--|---|--|--|--|---|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |

22a. I certify that (I) (this hospital) attended the deceased from 1/14/81, 19 81, to 1/24/81, 19 81, that (I) (we) lost saw the deceased alive on 1/14/81, 19 81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death.

| | | | | | | | |
|---|--|--|--|--|--|---------------------------------|--|
| 22b. SIGNATURE <u>Joseph A. Grasso</u> | | DEGREE <u>MD</u> | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/24/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Joseph A. Grasso</u> | | 22e. ADDRESS <u>5715600 / Mt 21801</u> | | | | | |

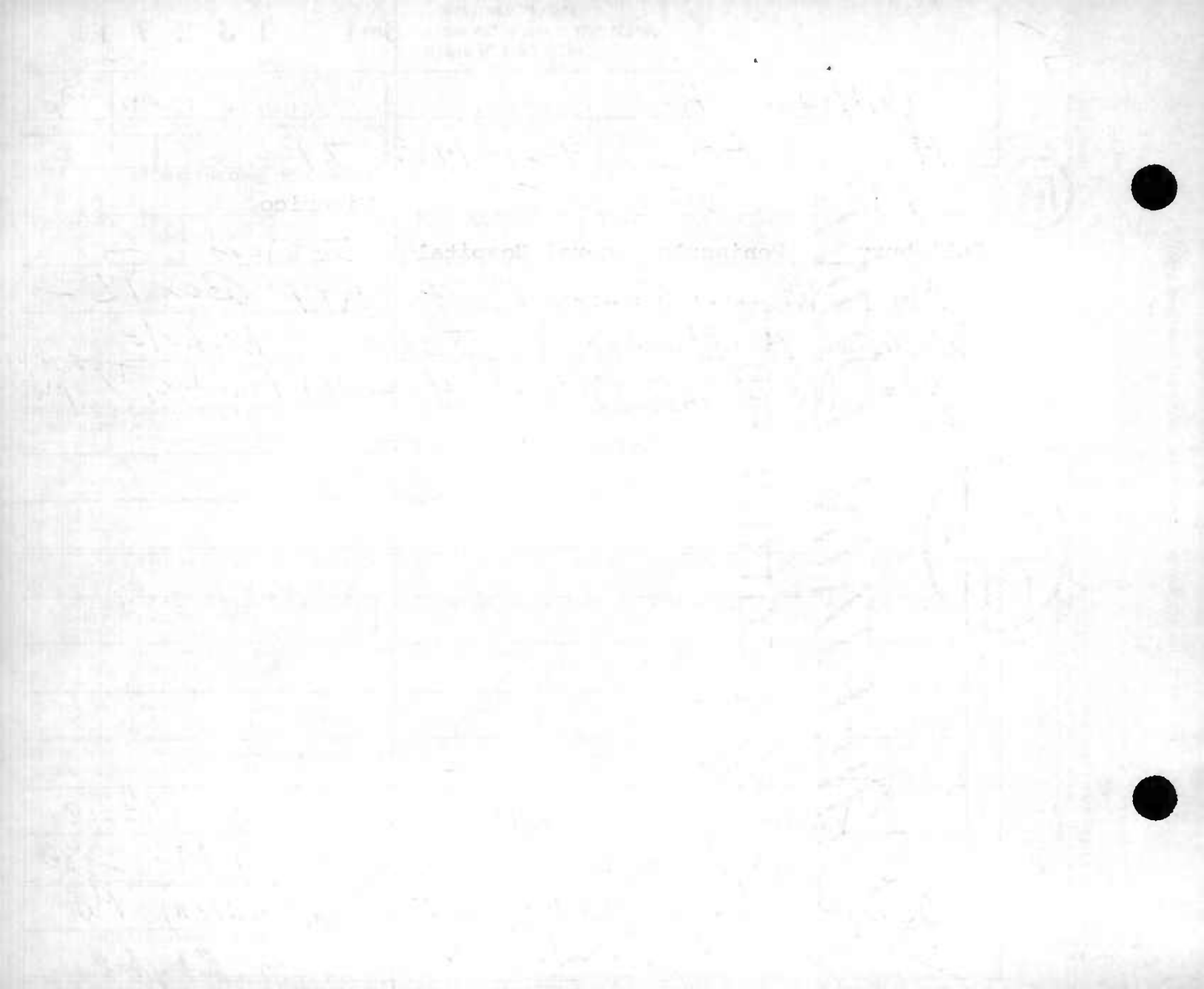
| | | | | | | | |
|--|--|--------------------------|--|--|--|--|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | 23b. DATE <u>1/24/81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>White Haven Cem.</u> | | 23d. LOCATION CITY OR TOWN <u>White Haven</u> COUNTY <u>Mt</u> STATE <u>MD</u> | |
| 24. FUNERAL DIRECTOR NAME <u>Compassion</u> ADDRESS <u>Biville, Md</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 21 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>R. J. Kelly</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03292 | |
|---|--|--|--|---|--|--|---|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) HAZEL C. MARSHALL | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 26, 1981 | | | 2b. HOUR 12 15 A M | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Aug. 16, 1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | | 12b. KIND OF BUSINESS OR INDUSTRY - - - - | | |
| 13a. STATE Maryland | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Tylerton | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS - - - (21866) | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Newell J. Bradshaw | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Audrey Marsh | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. 219-60-2098 | | 17. INFORMANT Fred G. Marshall | | | | ADDRESS Same as 43 a,b,c,d,e | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 1749 hepatic failure due to metastasis from breast cancer DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (b) metastasis from breast cancer (c) - | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/23 , 19 81 , to 1/26 , 19 81 , that (I) (we) lost saw the deceased alive on 1/26 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE OF PHYSICIAN Joseph A. Grasso | | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/26/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph A. Grasso | | | | | | 22e. ADDRESS 1300 S. Division St. Salisbury, Md. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/29/81 | | 23c. NAME OF CEMETERY OR CREMATORY Tylerton Church Cem. | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Tylerton Somerset Md. | | | |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons | | | | | | ADDRESS Crisfield, Md. 21817 | | | 25a. DATE REC'D. BY REGISTRAR FEB 0 1981 | | |
| | | | | | | 25b. REGISTRAR'S SIGNATURE Kirby McCreedy | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

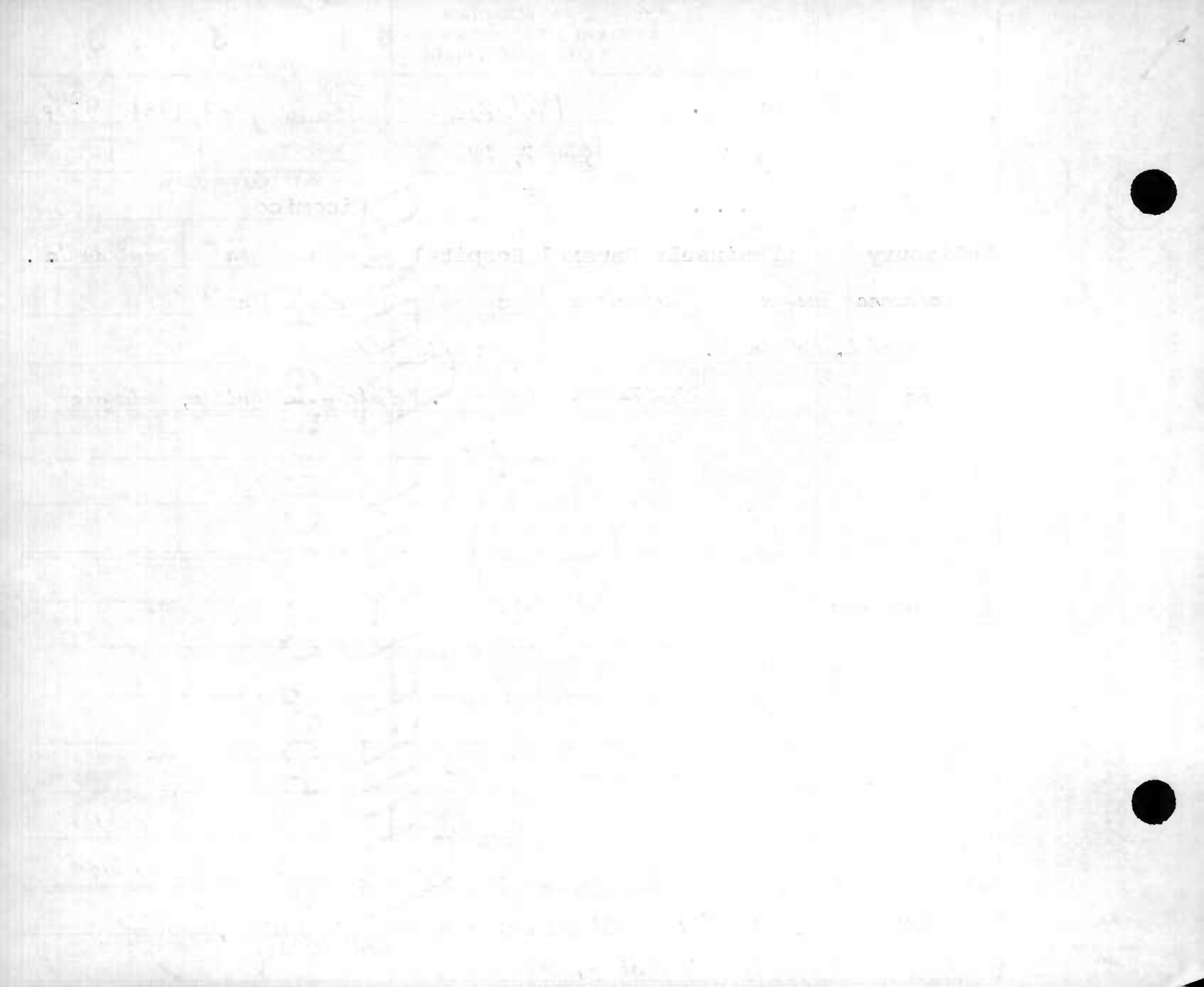
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1- FOR
STATE
REGISTRARSTATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03293

| | | | | | | | | | |
|---|--|--|---|---|--|--|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) <i>Chester A. McCabe</i> | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 13, 1981</i> | | | 2b. HOUR <i>9:29 PM</i> | | | |
| 3. SEX <i>male</i> | | 4. RACE <i>white</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>June 7, 1892</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) <i>88</i> YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. IF UNDER 24 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD. | | | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>poultry buyer</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>poultry ind.</i> | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY <i>Delaware Sussex</i> | | 13c. CITY OR TOWN <i>Selbyville</i> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <i>McCabe Street</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>Caleb L. McCabe Sr.</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Argelie Watson</i> | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>no</i> | | 16b. SOCIAL SECURITY NO. <i>222-07-2609</i> | | 17. INFORMANT ADDRESS <i>Layton W. McCabe - Selbyville, Delaware</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary failure</i> <i>4292</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction Cardiovascular Disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>10-30-</i> 19 <i>80</i> , to <i>1-13-</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>11-7-</i> 19 <i>80</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <i>James H. Carrford</i> | | | DEGREE <i>M.D.</i> ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <i>1-13-81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JAMES H. CARRFORD</i> | | | 22e. ADDRESS <i>#12 Medical Center Salisbury, Md</i> | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i> | | | 23b. DATE <i>1/16/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Bishopville Maryland</i> | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS <i>Richard T. Watson Selbyville, Delaware</i> | | | | | 25a. DATE OF REGISTRATION <i>JAN 15 1981</i> 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03294

1- FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|--|--|--|---|---|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) Evelyn B. McCarty | | | 7a. DATE OF DEATH MONTH DAY YEAR 1/2/81 | | | 7b. HOUR 3:45 PM | | | |
| 3. SEX F | | 4. RACE W | | 5. DATE OF BIRTH MONTH DAY YEAR 9-1-1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Cal MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY Wife Own | |
| 13a. STATE MD | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Simon A. Bowman | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Adz | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | |
| 16b. SOCIAL SECURITY NO. - | | | 17. INFORMANT NAME ADDRESS John J. McCarty, Bivulve, MD | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Stroke DUE TO, OR AS A CONSEQUENCE OF (b) High Blood Pressure & Cerebral Perfusion DUE TO, OR AS A CONSEQUENCE OF (c) Unknown APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days 38 days Unknown | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | |
| 19a. DATE OF OPERATION 11/24/80 | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED Cerebral Perfusion | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINERS) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18a, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/24/80 to 1/2/81 19____, that (I) (we) last saw the deceased alive on 1/2/81 19____, and that in (my) (our) opinion death occurred on the date (and hour) and from the causes stated above. (If we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE [Signature] | | | DEGREE | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/2/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr. Phary | | | 22e. ADDRESS Salisbury MD | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Buried | | | 23b. DATE 1/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY Bivulve Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Bivulve, MD | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS [Signature] | | | 25a. DATE REC'D. BY REGISTRAR JAN 8 1981 | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

MEDICAL CERTIFICATION

29

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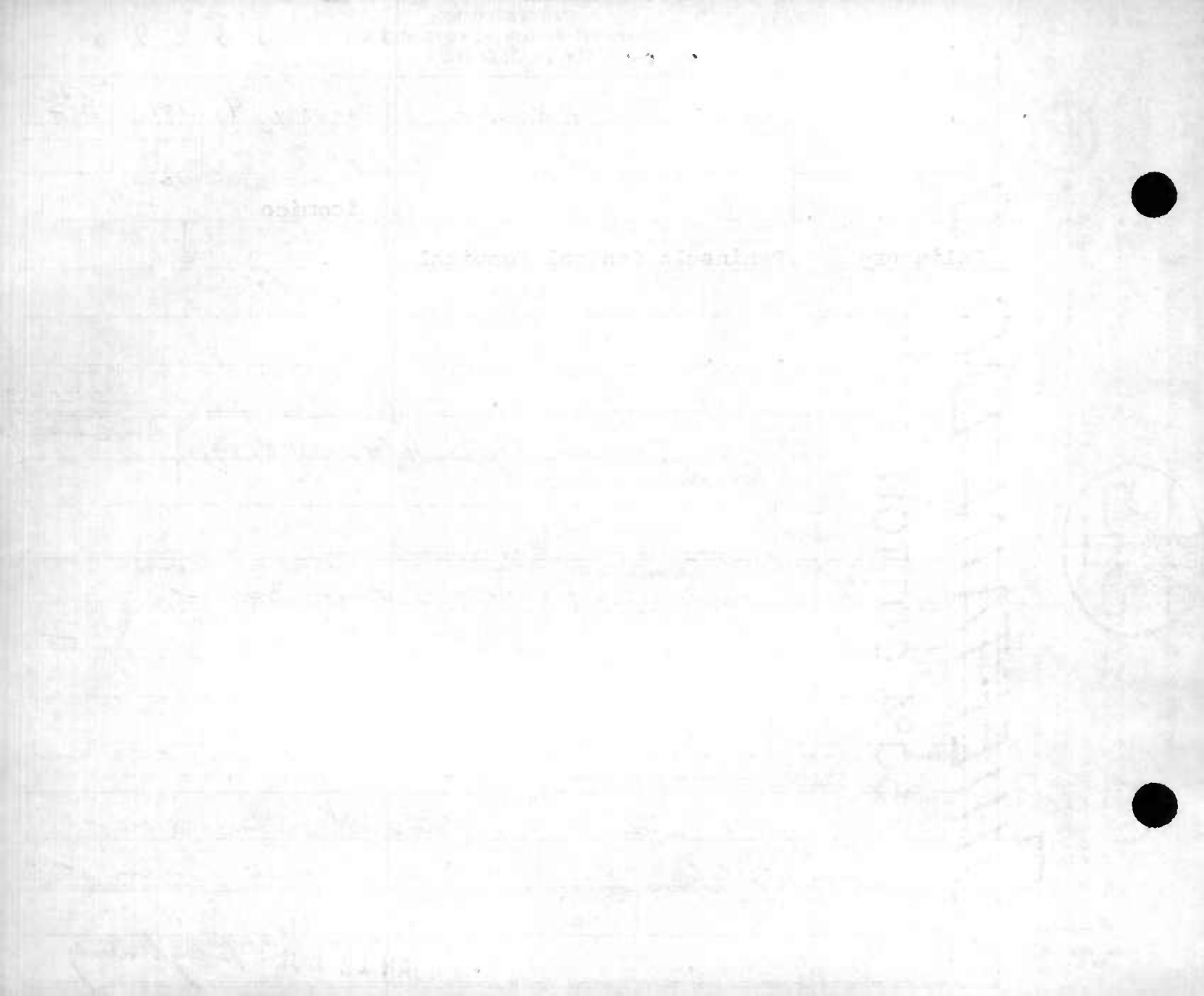
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03295 | |
|--|--|---|---|--|---|--|--------------------------------------|--|-------------------------|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Edith Eliza Meinster | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 9, 1981 | | | 2b. HOUR 3:40 A.M. | | | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR June 21, 1928 | | 6. AGE (IN YEARS LAST BIRTHDAY) 52 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Seaford, Del. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Registered Nurse | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE 13b. COUNTY 13c. CITY OR TOWN Maryland Worcester Posomoke City | | | | | 13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input type="checkbox"/> NO | | 13e. STREET ADDRESS 11 Second Street | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Minnard V. Hill | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Helen (unknown) | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-32-0692 | | 17. INFORMANT ADDRESS Dr. Leon Meinster (husband) same as 13 | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Metastatic Cystadenocarcinoma Ovary 1830 DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a): Partial intestinal obstruction - Pulmonary Fibrosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12-23-1980, to 1-9-1981, that (I) (we) lost the deceased alive on 1-8-1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (and) not view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE James H. Clifford M.D. | | | DEGREE M.D. | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1-9-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) James H. Clifford M.D. | | | 22e. ADDRESS #12 Medical Center Salisbury, Md. | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | | 23b. DATE 1/10/81 | | 23c. NAME OF CEMETERY OR CREMATORY Delmarva Crematory | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Lewes, Sussex, Delaware | | | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of same.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03296 | |
|---|--|--|--|---|--|--|--|--|--|-----------------------------------|--|
| 1. FOR STATE REGISTRAR | | 1. DECEASED NAME (TYPE OR PRINT) | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR | |
| | | Nada B MENZEL | | | | | | 1-26-81 | | 8:30 P M | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH MONTH DAY YEAR | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| F | | W | | 6-20-90 | | 90 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Maryland | | U.S. | | | | Wicomico County MD | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| Salisbury | | Salisbury Nursing Home | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | |
| Maryland | | Somerset | | Oriole | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| Thomas A. Bozman | | | | Mary Lawrence | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | | |
| no | | | | | | Mr. Herman Bozman, Nelsonia, Va. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary thrombosis</i> 4340 DUE TO, OR AS A CONSEQUENCE OF (b) <i>gen arteriosclerosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>1 wk - 4 wks -</i> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): <i>atrial fibrillation</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 19c. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 19d. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| | | | | | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 20b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 20c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | | | |
| | | P.M. 19 | | | | | | | | | |
| 21a. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21b. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21c. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| | | | | | | | | | | | |
| 22. I certify that (I) (the hospital) attended the deceased from <i>2/25</i> 19 <i>81</i> to <i>1/26</i> 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/25</i> 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (if (we) did) (did not view the body after death). | | | | | | | | | | | |
| 22a. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <i>Earl M. Beardsley</i> | | | | MD | | | | | | <i>1/27/81</i> | |
| 22b. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| DR. EARL M. BEARDSLEY | | | | CIVIC AVE. SALISBURY, MD. 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| Burial | | 1/29/81 | | Oriole | | Oriole, Somerset, Md | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| <i>James L. Newman</i> | | | | Princess Anne | | JAN 30 1981 | | <i>Butry Hobing</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03297

| | | | | | | | | | |
|---|--|---|--|--|--|---|--|--|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST MARTHA B. MERRITT | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 1 1981 | | | | 2b. HOUR 7:30 P.M. | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 7 10 1910 | | 6. AGE (IN YEARS LAST BIRTHDAY) 70 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) SALISBURY NURSING HOME | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN EDEN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Peter Hopkins | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST DOLLIE REVELL | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 200-12-1408 | | 17. INFORMANT Robert Young - 723 PRINCESS ANNE RD Somerset Ave | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per part. (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 day yrs. | | | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) Diabetes Mellitus Chronic Obs Lung Disease | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE 1/12 1980 to 1/1 1981 | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/31 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Earl M. Beardsley | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/2/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, M.D. | | | | 22e. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/3/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Presbyterian Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Princess Anne Somerset MD | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | | | ADDRESS Salisbury, MD | | 25a. DATE BY REGISTERAR JAN 6 1981 | | 25b. REGISTERAR SIGNATURE | |

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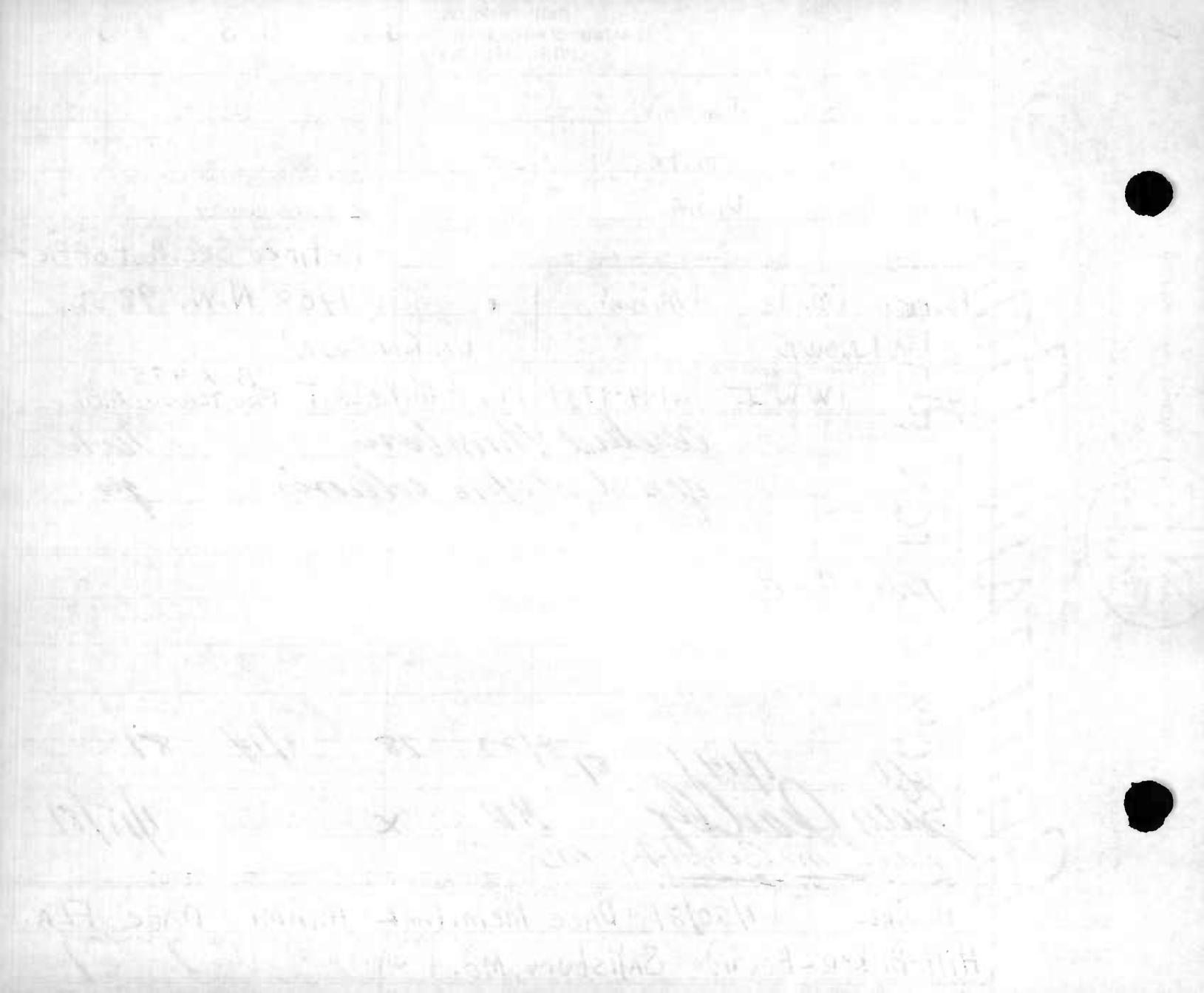
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TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

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MEDICAL CERTIFICATION

| FOR 1 - STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | 0 3 2 9 8 REG. NO. | | | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | | | 2a. DATE OF DEATH | | | | 2b. HOUR | | | |
| FIRST MIDDLE LAST Lula JORDAN MIKELAIT | | | | MONTH DAY YEAR 1-14-81 | | | | 8:30 PM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS | |
| Female | | White | | MONTH DAY YEAR 1-1-95 | | 86 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| Phila., Pa. | | U.S.A. | | | | Wicomico county MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Salisbury Nursing Home | | | | Retired Sec. Post Office | | | | | |
| 13a. STATE | | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Florida | | | | Dade | | Miami | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 1408 N.W. 98 St. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | | | | | | |
| UNKNOWN | | | | UNKNOWN | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE YEAR OR DATES) | | 17. INFORMANT | | ADDRESS | | | |
| Yes | | | | WW I | | DAVID MIKELAIT | | Box 495 FRUITLAND, Md. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line (a), (b), (c), (d). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DOE TO, OR AS A CONSEQUENCE OF (b) <u>generalized arteriosclerosis</u> DOE TO, OR AS A CONSEQUENCE OF (c) <u></u> (d) <u></u> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 wk.</u> <u>yr.</u> | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>prev. CVA.</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/14/81</u> to <u>1/14/81</u> that (I) (we) last saw the deceased alive on <u>1/14/81</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) did (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| <u>EARL M. BEARDSLEY MD.</u> | | | | MD | | | | | | <u>1/15/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| <u>DR. JORGE C. FLORES MD.</u> | | | | <u>CIVIC AVE. SALISBURY, MD. 21801</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | |
| <u>BURIAL</u> | | | | <u>1/20/81</u> | | <u>Dade Mem. Park</u> | | <u>MIAMI Dade FLA.</u> | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | |
| <u>Hill-Baker-Bownds</u> | | | | <u>Salisbury, Md.</u> | | | | <u>JAN 19 1981</u> | | <u></u> | |



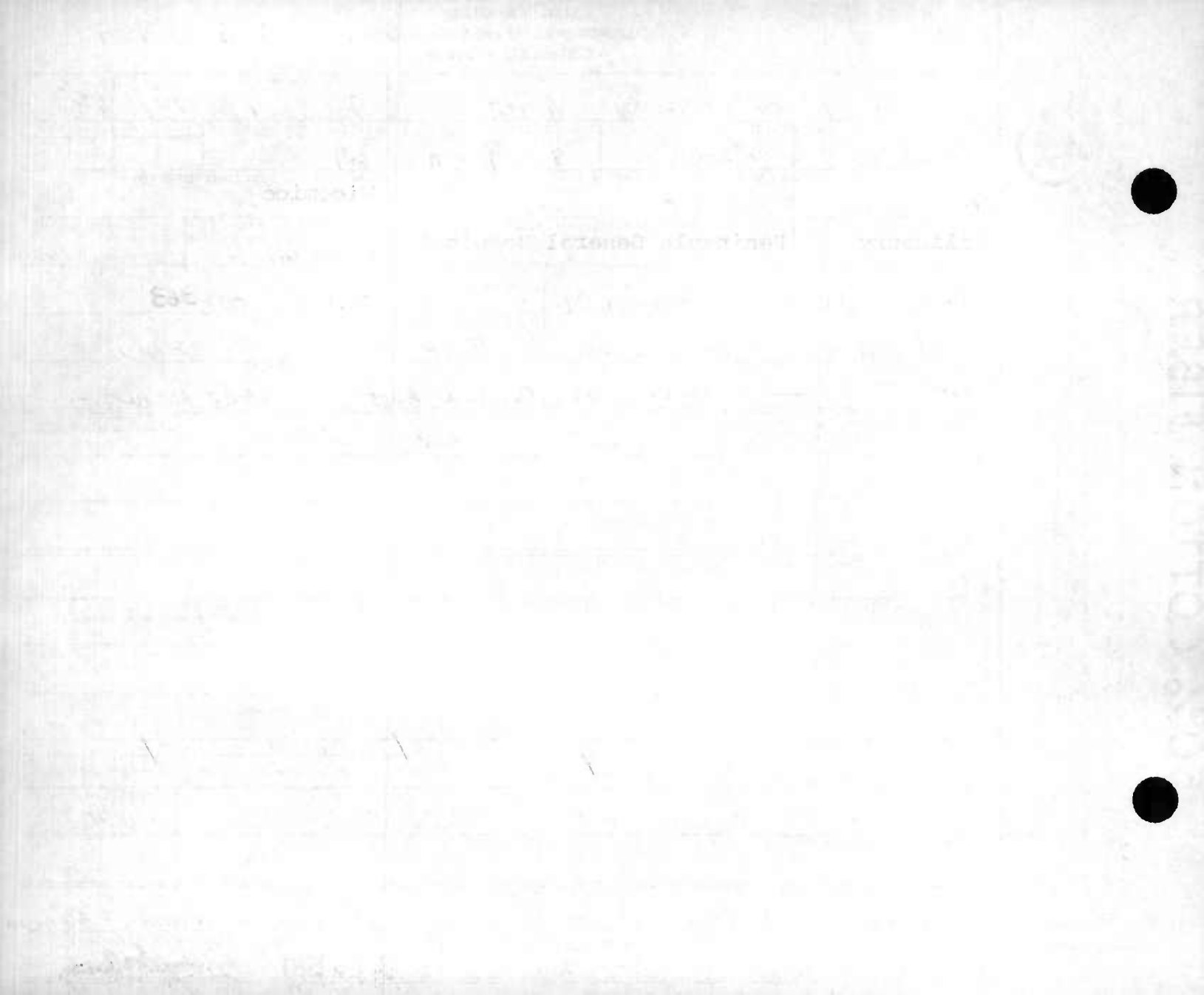
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours of death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of one.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03299 | |
|---|--|--|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) EMILY BRITTINGHAM Mills | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 11, 1981 | | | 2b. HOUR 6:50 M | | |
| 3. SEX Female | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 8 9 11 | | 6. AGE (IN YEARS LAST BIRTHDAY) 69 YRS. | | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) OK HALL, VA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired laborer | | | 12b. KIND OF BUSINESS OR INDUSTRY Packing Co | | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | 13e. STREET ADDRESS RED 2 Box 363 | | |
| 13a. STATE MARYLAND | | 13b. CITY OR TOWN Worcester | | 13c. CITY OR TOWN Pocomoke City | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST WILSON BRITTINGHAM | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ELLA KNOX | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 212-22-9275 | | 17. INFORMANT OLIVIA M. AMES | | | | ADDRESS SAME AS ABOVE | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) gangrene toes; cytotoxic; diabetes 2506 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 12/15 , 19 80 , to 1/11 , 19 81 , that (I) (we) last saw the deceased alive on 1/11 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE M B Turner MD | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/11/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY GEORGETOWN A.M.E. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke City Worcester MARYLAND | | | |
| 24. FUNERAL DIRECTOR NAME John's Memorial Chapel | | | | ADDRESS Rt #2 Jersey Rd Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 16 1981 | | 25b. REGISTRAR'S SIGNATURE Robert M. ... | | | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03300 | |
|---|--|--|--|--|---|---|---|--|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) BENJAMIN JASON MORRIS | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 30, 1981 | | | 2b. HOUR 8:10 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 1 27 1919 | | 6. AGE (IN YEARS, LAST BIRTHDAY) 62 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Retired Shore Land Freezer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MARYLAND | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN PARSONSBURG | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt #1 LAWS Rd. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST BENJAMIN MORRIS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST JULIA MORRIS | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | 16b. SOCIAL SECURITY NO. 220-01-9168 | | 17. INFORMANT Ruth P. Morris | | ADDRESS LAWS RD Rt #1 PARSONSBURG, MD 21849 | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: Thrombotic Retardation 2501 IMMEDIATE CAUSE (a) Electrolyte Imbalance DUE TO, OR AS A CONSEQUENCE OF (b) Arterial Plaque Block DUE TO, OR AS A CONSEQUENCE OF (c) Low Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) General Debility; Recent Arteriosclerosis | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/29 19 81 to 1/30 19 81 , that (I) (we) lost saw the deceased alive on 1/30 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Helen M. Baldado | | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | 22c. DATE SIGNED 1/30/1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Helen M. BALDADO | | | | | 22e. ADDRESS Salisbury, Md 21801 | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 2/2/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill Mem Ga | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron Wicomico MD | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds ADDRESS Salisbury, Md. | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |

BP



Wichita

Benjamin's General Hospital

Holbrook

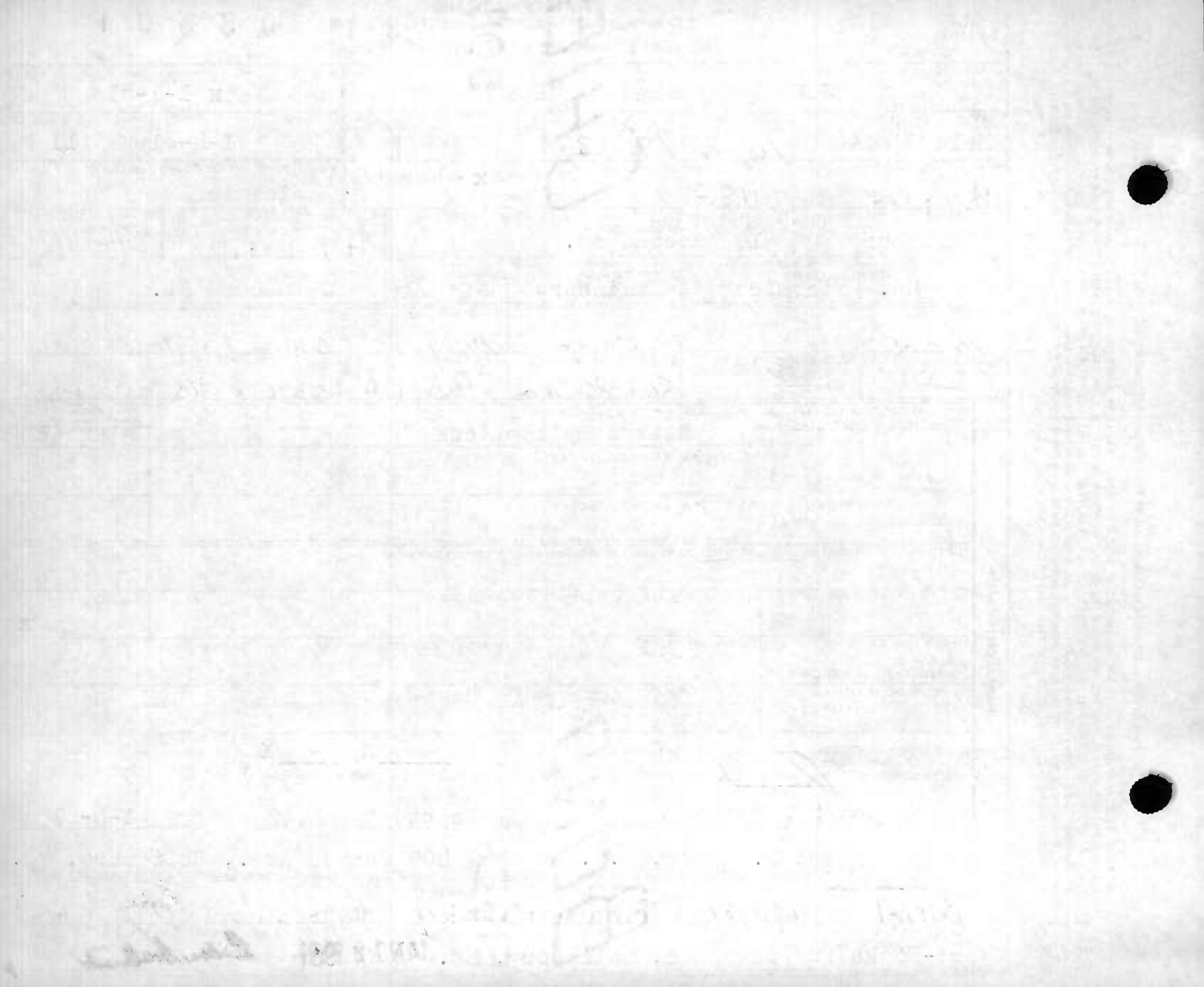
1900-1901

1900-1901

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03301 REG. NO. | |
|---|--|--------------------------------|--|---|--|---|--|---|----------------------|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) JOHN THOMAS NEWSOME | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> 1-4-81 | | 2b. HOUR P | | |
| 3. SEX Male | | 4. RACE AA | | 5. DATE OF BIRTH MONTH 10 DAY 26 YEAR 17 | | 6. AGE (IN YEARS) LAST BIRTHDAY 63 YRS. | | IF UNDER 1 YR. MONTHS 0 DAYS 0 HOURS 0 MIN 0 | | 2c. DATE PRONOUNCED DEAD MONTH 1 DAY 4 YEAR 81 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Perry, GA. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 105 Second St. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) H-D-Metal | | 12b. KIND OF BUSINESS OR INDUSTRY Steel | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Md. | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 105 Second St. | | | |
| 14. FATHER'S NAME FIRST Thomas MIDDLE Newsome LAST Newsome | | | | | | 15. MOTHER'S MAIDEN NAME FIRST Mary MIDDLE Annie LAST Newsome | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. 261-26-712 | | 17. INFORMANT ADDRESS Redolia Newsome 105 Second St. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Status Epilepticus 3453 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | | | | | TITLE (SPECIFY) Deputy | | DATE SIGNED 1-6-81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL OR CREMATION REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/11/81 | | 23c. NAME OF CEMETERY OR CREMATORY Travel Rest Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Montezuma GA. | | | |
| 24. FUNERAL DIRECTOR NAME West-Fooks Funeral Home, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 12 1981 | | 25b. REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

BP _____

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03302 | | | | | |
|---|--|---|--|---|---|--|--|---|--|--|--|---|--|----------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Thomas William NICHOLS | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR JAN 4 1981 | | 2b. HOUR 4:31 AM | |
| 3. SEX MALE | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Jan. 24, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 | | 7. IF UNDER 1 YEAR MONTHS DAYS 11 10 | | 7. IF UNDER 24 HRS. HOURS MIN. 11 10 | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? U. S. A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Ret. Janitor | | 12b. KIND OF BUSINESS OR INDUSTRY Salis. Armory | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Delmar | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. #3 Waller Road | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George W. Nichols | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Dora J. Nichols | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 220-10-9933 | | 17. INFORMANT ADDRESS Howard Nichols Rt. #3 Delmar, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Heart Failure 4960 DUE TO, OR AS A CONSEQUENCE OF (b) Advanced Chronic Obstructive Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. } DUE TO, OR AS A CONSEQUENCE OF (c) Pulmonary Disease | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) Quenched Arteriosclerosis | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/4 19 81 , to 1/4 19 81 , that (I) (we) last saw the deceased alive on 1/4 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE Helen M. Baldado | | DEGREE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/4/81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) HELEN M. BALDADO | | 22e. ADDRESS 542 RIVERSIDE DRIVE SALISBURY MD. 21701 | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1-7-1981 | | 23c. NAME OF CEMETERY OR CREMATORY St. Stephens Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Delmar Sussex Del. | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Marvel-Short Funeral Home Inc. | | 24b. DATE REC'D. BY REGISTRAR JAN 7 1981 | | 24c. REGISTRAR'S SIGNATURE [Signature] | | | | | | | | | | | |

1950

Wichita

General Hospital

Wichita

Wichita

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed in the office of the Registrar within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03303

| | | | | | |
|--|---|---|---|--|-----------------------------------|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | MONTH DAY YEAR | |
| CONSTANCE E NIXON | | | | January 21, 1981 4:05 PM | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | |
| FEMALE | BLACK | MONTH DAY YEAR | | 66 YRS. | |
| | | 3 17-1914 | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 7b. CITIZEN OF WHAT COUNTRY? | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | |
| MD | U.S.A. | | | Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY |
| Salisbury | Peninsula General Hospital | | BD. OF EDUCATION | | |
| 13a. STATE | | 13b. COUNTY | 13c. CITY OR TOWN | 13d. INSIDE CITY LIMITS? | |
| MD | SOMERSET | PRINCESS ANNE | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS | |
| 14. FATHER'S NAME FIRST MIDDLE LAST | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST | | 16. SOCIAL SECURITY NO. | |
| SALL ROBERTS | | LEAH E ROBERTS | | 17. INFORMANT ADDRESS | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | |
| 2 | | | | PR. ANNE GEORGE F. N. NIXON, 406 BEECHWOOD ST. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | |
| PART I. DEATH WAS CAUSED BY: | | | | | |
| IMMEDIATE CAUSE (a) G.I. Bleeding secondary to | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (b) Ovarian Cancer | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF | | | | | |
| (c) | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? | |
| | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| | | P.M. 19 | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/10/81, 1981, to 1/21, 1981, that (I) (we) lost saw the deceased alive on 1/21, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE Joseph A. Grasso | | | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | |
| Joseph A. Grasso | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | |
| | | 1-24-81 | | John Wesley | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D. BY REGISTRAR | |
| Addie Jones, 407 Somerset Ave. P. Anne | | | | JAN 28 1981 | |
| | | | | 25b. REGISTRAR'S SIGNATURE | |
| | | | | Barry McQuinn | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 1 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03304 | |
|--|--|--|---|---|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 1. DECEASED NAME (TYPE OR PRINT) <i>Thomas C. Oliphant</i> | | | | 2a. DATE OF DEATH MONTH DAY YEAR <i>January 9, 1981</i> | | | 2b. HOUR <i>12:45 PM</i> | |
| 3. SEX <i>Male</i> | | 4. RACE <i>Cauc.</i> | | 5. DATE OF BIRTH MONTH DAY YEAR <i>Nov. 25, 1907</i> | | 6. AGE (IN YEARS LAST BIRTHDAY) YRS. MONTHS DAYS <i>73</i> | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <i>Delaware</i> | | 7b. CITIZEN OF WHAT COUNTRY? <i>USA</i> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <i>Wicomico</i> MD. | | | | | |
| 10. CITY OR TOWN OF DEATH <i>Salisbury</i> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <i>Peninsula General Hospital</i> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <i>route salesman</i> | | 12b. KIND OF BUSINESS OR INDUSTRY <i>automotive</i> | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE <i>Maryland</i> | | 13b. COUNTY <i>Wicomico</i> | | 13c. CITY OR TOWN <i>Salisbury</i> | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS <i>rd2 Log Cabin Road</i> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <i>James J. Oliphant</i> | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <i>Anna M. Baker</i> | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <i>yes</i> | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) <i>WW11</i> | | 17. INFORMANT ADDRESS <i>Salisbury, Md.</i> | | 17. INFORMANT NAME <i>Mrs. Nelva B. Oliphant rd2 Log Cabin Road</i> | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Respiratory failure due to some chronic</i> 4960 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>obstructive pulmonary disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I: (a) <i>chronic Congestive Heart Failure, Renal Failure, cardiovascular disease</i> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18. PART I OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <i>6/6</i> , 19 <i>75</i> , to <i>1/9</i> , 19 <i>81</i> , that (I) (we) last saw the deceased alive on <i>1/9</i> , 19 <i>81</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <i>Joseph Z. Adaros</i> | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED <i>1-9-81</i> | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <i>JOSEPH Z. ADAROS MD.</i> | | | | 22e. ADDRESS <i>329 FLORIDA AV SALISBURY MD 21801</i> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>burial</i> | | 23b. DATE <i>1/12/81</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Odd Fellows Cemetery</i> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <i>Laurel Sussex Delaware</i> | | | | | |
| 24. FUNERAL DIRECTOR NAME <i>Homer L. Disharoon box 678 Laurel Del</i> | | | | | | 25a. DATE REC'D. BY REGISTRAR <i>JAN 14 1981</i> | | 25b. REGISTRAR'S SIGNATURE <i>Jeffrey M. Brady</i> | | | |

MEDICAL CERTIFICATION

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BP

1938-1

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If Item 21 is marked or Item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03305 | | | |
|--|--|--|--|---|--|--|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST WILLIAM David OLIPHANT | | | | JANUARY 7 1981 | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Oct. 13, 1906 | | 6. AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Laurel, Del. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) PENINSULA GENERAL HOSPITAL | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Machinist | | 12b. KIND OF BUSINESS OR INDUSTRY Auto | |
| 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ode Oliphant | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Addie Elliott | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 217-10-2204 | | 17. INFORMANT ADDRESS Mr. Dan Hitchens; Rt. 5, Box 527, Salisbury, Md. Rd. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a). Pulmonary Embolus DUE TO, OR AS A CONSEQUENCE OF (b). metastatic carcinoma DUE TO, OR AS A CONSEQUENCE OF (c). APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH min mos | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). S/P pneumonectomy - 1942 | | | | | | | |
| 19a. DATE OF OPERATION 1991 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. LOCATION CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1-7-81 to 1-7-81, 1981, that (1) (we) last saw the deceased alive on 1-7-81, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (1) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE John T. Bulkeley MD. | | DEGREE MD | | | | 22c. DATE SIGNED 1/12/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN T. BULKELEY MD. | | 22e. ADDRESS PINE BLUFF ROAD SALISBURY, MD. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/9/81 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury, Wic., Maryland | |
| 24. FUNERAL DIRECTOR HOLLOWAY FUNERAL HOME, Salisbury, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03306 | |
|--|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) HAROLD A. PEMBER | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 3, 1981 | | | 2b. HOUR 12:25 AM | | | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 12, 1895 | | 6. AGE (IN YEARS LAST BIRTHDAY) 85 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | 8. IF UNDER 74 HRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Kansas | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Farmer | | 12b. KIND OF BUSINESS OR INDUSTRY Self Employed | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | 13b. COUNTY Somerset | | 13c. CITY OR TOWN Crisfield | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 1 Box 278 - Lawsonia | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles Ormsby Pember | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Enna Spaulding | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | | | 16b. SOCIAL SECURITY NO. W. W. I 557-10-2129 | | 17. INFORMANT Vina P. Pember | | | | ADDRESS Same as 13 a,b,c,d,e | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: 5860 IMMEDIATE CAUSE (a) <u>renal failure</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a). <u>diabetes mellitus</u> | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12/29</u> , 19 <u>80</u> , to <u>1/3</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/2</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Rodney A. Wernich</u> | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1/3/81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) RODNEY A. WERNICH | | | | 22e. ADDRESS KAY AVE. SALISBURY Md. 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/5/81 | | 23c. NAME OF CEMETERY OR CREMATORY Asbury Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Crisfield Somerset Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Bradshaw & Sons | | | | ADDRESS Crisfield, Md. 21817 | | | | 25a. DATE REC'D. BY REGISTRAR JAN 7 1981 | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

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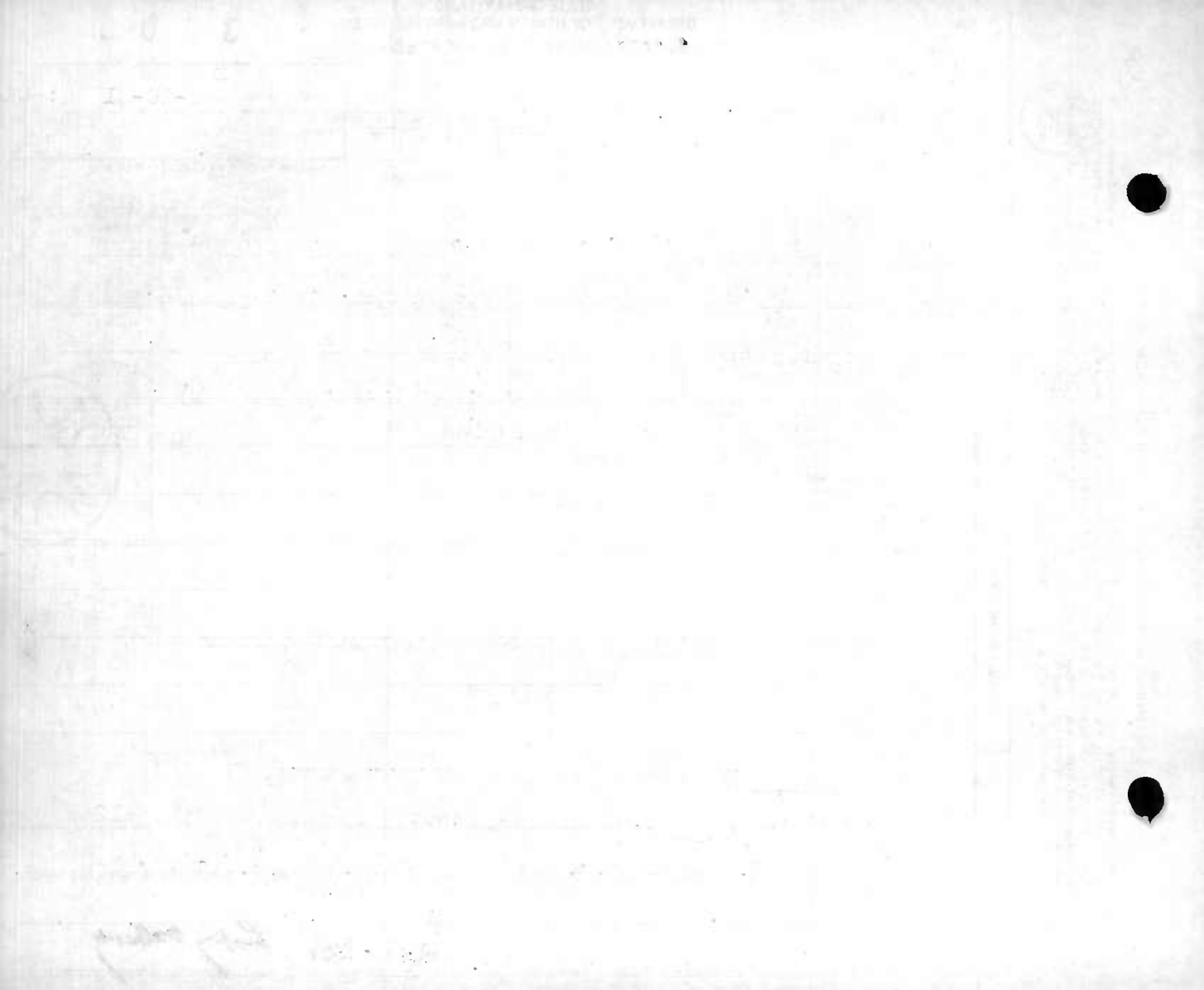
DHMH-17
(VR A15 ME(5))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03307 REG. NO. | |
|--|--|-------------------------|--|---|--|---|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mervin Louis Pennewell | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-28-81 | | 2b. HOUR 1:30 AM | | | |
| 3. SEX Male | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 6/14/1932 | | 6. AGE (IN YEARS LAST BIRTHDAY) 48 YRS. | | 7c. DATE PRONOUNCED DEAD MONTH DAY YEAR Jan. 28 1981 | | 2d. HOUR 11 AM | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Virginia | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Hotel Esther | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Construction | |
| 13a. STATE Maryland | | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 805 E. Church Street | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Zedoc Thomas Pennewell | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Bertie Mae Bailey | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 214-34-5292 | | 17. INFORMANT (sister) Rt. 1 Mrs. Mildred Townsend, Salisbury, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Gastric Hemorrhage DUE TO, OR AS A CONSEQUENCE OF (b) Chronic Alcoholism DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH minutes years | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE  | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | DATE SIGNED 1/29/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/30/81 | | 23c. NAME OF CEMETERY OR CREMATORY Union Meth. Ch. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Greenbackville Virginia | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE  | | | |

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH, IF ANY DELAY IS NECESSARY. PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1B. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH-17
(VR A15 ME (5))
30M 7/73

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 03308 | |
|---|--|-------------------------|--|--|--|--|--|---|--|---|--|
| FOR 1- STATE REGISTRAR | | | | | | | | | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Lolly Marie Perdue | | | | | | | | | | 2a. DATE KNOWN OF DEATH EST. MATED <input checked="" type="checkbox"/> 1-10-81 4:50A | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR 9/25/1912 | | 6. AGE (IN YEARS) LAST BIRTHDAY 68 YRS. | | IF UNDER 1 YR. MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Taylorville, Md. | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY none | |
| 13. USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Salisbury | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Rt. 3, Shavox Road | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Levin Timothy Layton | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Mary Elizabeth Jarvis | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS same as 13 Mr. Virgil C. Perdue (husband) | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last: DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | | | | | TITLE (SPECIFY) M.D. Deputy | | DATE SIGNED 1/12/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY Parsonsborg Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Parsonsborg, Wic. Md. | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 14 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Earl L. Royer</i> | | | |



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

03309

1. FOR
STATE
REGISTRAR

REG. NO.

| | | | | | | | | | |
|---|--|--|---|--|--|---|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Charles A. Perry | | | 2a. DATE OF DEATH MONTH DAY YEAR January 1 1981 | | | 2b. HOUR 6:30 P.M. | | | |
| 3. SEX Male | | 4. RACE AA | | 5. DATE OF BIRTH MONTH DAY YEAR 3-27-1922 | | 6. AGE (IN YEARS LAST BIRTHDAY) 58 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MJ | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Sea Food Ind. | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MJ | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Quantico | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS RT 1 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George J. Perry | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Jenora Jones | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WW II | | 17. INFORMANT ADDRESS Alma Perry, Quantico, MD | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) PROBABLE PULMONARY EMBOLUS. 1579 DUE TO, OR AS A CONSEQUENCE OF (b) PANCREATIC CARCINOMA. Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH TERMINAL 4 months | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | |
| 19a. DATE OF OPERATION 8/25/80 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED PANCREATIC CARCINOMA | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 8-25- 19 80 , to 12-23 19 80 , that (I) (we) last saw the deceased alive on DECEMBER 19 80 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE John A. Bartkovich | | | | DEGREE MD ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 1/4/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) JOHN A. BARTKOVICH | | | | 22e. ADDRESS MEDICAL CENTER SALISBURY MD | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL, (SPECIFY) Quantic | | 23b. DATE 1/6/81 | | 23c. NAME OF CEMETERY OR CREMATORY Nanticoke Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Nanticoke, MD | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Amessick, Bivalve, MD | | | | 25a. DATE REC'D. BY REGISTRAR JAN 9 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Barbara Brady</i> | | | |

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



Handwritten text at the top of the page, including a date and possibly a name.

Main body of handwritten text, consisting of several lines of cursive script.

Handwritten text in the middle section, possibly a signature or a closing.

Handwritten text at the bottom of the page, including a date and possibly a name.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.
IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| 1- FOR STATE REGISTRAR | | | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03310 | | | |
|--|--|---|--|--|--|--|--|--|--|---|--|
| 1 DECEASED NAME (TYPE OR PRINT) RUTH SILVERMAN PHILLIPS | | | | 2a DATE OF DEATH 01 09 81 | | | | 2b HOUR 8:40 PM | | | |
| 3 SEX FEMALE | | 4 RACE WHITE | | 5 DATE OF BIRTH FEB. 14, 1906 | | 6 AGE (IN YEARS LAST BIRTHDAY) 74 YRS. | | 7 IF UNDER 1 YEAR MONTHS DAYS | | 8 IF UNDER 24 HRS HOURS MIN. | |
| 7a BIRTHPLACE (STATE OR FOREIGN COUNTRY) NEW YORK | | 7b CITIZEN OF WHAT COUNTRY? U.S.A. | | 8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | | | |
| 10 CITY OR TOWN OF DEATH SALISBURY | | 11 NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) WICOMICO NURSING HOME | | | | 12a USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b KIND OF BUSINESS OR INDUSTRY OWN HOME | | | |
| 13a USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b STATE Maryland | | | | 13c CITY OR TOWN Salisbury | | 13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e STREET ADDRESS 222 S. CLARKMONT DR | | | |
| 14 FATHER'S NAME FIRST MIDDLE LAST ALBERT HENRY SILVERMAN | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST LULA 7. Smith | | | | | | | |
| 16a WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 218-44-1685 | | 17 INFORMANT WALTER L. Phillips Sr. | | | | ADDRESS SAME AS 13e | | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) 4409 Congestive Heart Failure DUE TO, OR AS A CONSEQUENCE OF (b) Generalized Atherosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a DATE OF OPERATION | | | | 19b CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a I certify that (I) (this hospital) attended the deceased from 12-12-80, to 1-09-81, that (I) (we) lost saw the deceased alive on 12-29-80, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b SIGNATURE G.C. Mitchell, M.D. | | | | DEGREE M.D. | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c DATE SIGNED 12 Jan 81 | |
| 22d PHYSICIAN'S NAME (TYPE OR PRINT) G.C. Mitchell, M.D. | | | | 22e ADDRESS POB 2378 Salisbury, Md | | | | | | | |
| 23a BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b DATE 1/13/1981 | | 23c NAME OF CEMETERY OR CREMATORY PARSONS CEM | | 23d LOCATION CITY OR TOWN COUNTY STATE Salisbury Md | | | |
| 24 FUNERAL DIRECTOR NAME Hill-Baker-Bownds, Salisbury Md. | | | | 24b ADDRESS | | | | 25a DATE RECEIVED BY REGISTRAR | | 25b REGISTRAR'S SIGNATURE | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | REG. NO. 03311 | | | |
|---|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | 2a. DATE OF DEATH MONTH DAY YEAR 23, 1981 | | | |
| 1. DECEASED NAME FIRST MIDDLE LAST Earl W. Powell | | | | 2b. HOUR 8 A M | | | |
| 3. SEX Male | | 4. RACE white | | 5. DATE OF BIRTH MONTH DAY YEAR Feb. 14, 1896 | | 6. AGE (IN YEARS LAST BIRTHDAY) 84 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) retired farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Somerset 13c. CITY OR TOWN Rehobeth | | | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> 13e. STREET ADDRESS Rural | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Charles E. Powell | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sallie Dryden | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | 16b. SOCIAL SECURITY NO. 217-36-0767 | | 17. INFORMANT ADDRESS Gertrude M. Powell Route #1, Box 94 Pocomoke City, Md. | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Concussion of brain with acute trauma</u> 1579 DUE TO, OR AS A CONSEQUENCE OF (b) <u>meltd</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 6 mo | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) C | | | | | | | |
| 19a. DATE OF OPERATION 2 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED 2 | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 2 Jan 81, 19, to 23 Jan 81, 19, that (I) (we) lost saw the deceased alive on 23 Jan 81, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Andrew T. [Signature] | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 23 Jan 81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | 22e. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/25/81 | | 23c. NAME OF CEMETERY OR CREMATORY Rehobeth Pres. Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Rehobeth Somerset Md. | |
| 24. FUNERAL DIRECTOR NAME Scott S. Melson | | | | ADDRESS Pocomoke City, Md. | | 25a. DATE RECD. BY REGISTRAR 25. REGISTRAR'S SIGNATURE | |

BP _____



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 1 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03312 | | | |
|---|--|---|--|--|--|--|--|---|--|----------|--|--|--|
| 1- FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Edith ARVEY Purnell | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 Jan. 27 81 | | 2b. HOUR 11:50 AM | | | | | |
| 3. SEX Female | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR Nov. 29, 1884 | | 6. AGE (IN YEARS LAST BIRTHDAY) 96 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) DELAWARE | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Riverback Manor | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS John B. Parsons Home | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST William Dusky | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Martha J. Smith | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. 215-16-7859 | | 17. INFORMANT ADDRESS John B. Parsons Home, Lemmon Hill, Salisbury, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) generalized arteriosclerosis DUE TO, OR AS A CONSEQUENCE OF (c) URS | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 4 days | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 P.M. | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 7-24-25 , 19 81 , to 1-27 , 19 81 , that (I) (we) last saw the deceased alive on 1-27 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE John G. Bulkeley M.D. ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1-28-81 | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) John Bulkeley M.D. | | | | | | 22e. ADDRESS | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1-30-1981 | | 23c. NAME OF CEMETERY OR CREMATORY PARSONS Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds ADDRESS Salisbury Md. | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE | | | | | |

BP

| Date | | Description | | Amount | |
|------|-----|-------------|---------|--------|--|
| 1911 | 10 | Jan 1 | Balance | 100.00 | |
| 1911 | 11 | Jan 2 | Jan 2 | 100.00 | |
| 1911 | 12 | Jan 3 | Jan 3 | 100.00 | |
| 1911 | 13 | Jan 4 | Jan 4 | 100.00 | |
| 1911 | 14 | Jan 5 | Jan 5 | 100.00 | |
| 1911 | 15 | Jan 6 | Jan 6 | 100.00 | |
| 1911 | 16 | Jan 7 | Jan 7 | 100.00 | |
| 1911 | 17 | Jan 8 | Jan 8 | 100.00 | |
| 1911 | 18 | Jan 9 | Jan 9 | 100.00 | |
| 1911 | 19 | Jan 10 | Jan 10 | 100.00 | |
| 1911 | 20 | Jan 11 | Jan 11 | 100.00 | |
| 1911 | 21 | Jan 12 | Jan 12 | 100.00 | |
| 1911 | 22 | Jan 13 | Jan 13 | 100.00 | |
| 1911 | 23 | Jan 14 | Jan 14 | 100.00 | |
| 1911 | 24 | Jan 15 | Jan 15 | 100.00 | |
| 1911 | 25 | Jan 16 | Jan 16 | 100.00 | |
| 1911 | 26 | Jan 17 | Jan 17 | 100.00 | |
| 1911 | 27 | Jan 18 | Jan 18 | 100.00 | |
| 1911 | 28 | Jan 19 | Jan 19 | 100.00 | |
| 1911 | 29 | Jan 20 | Jan 20 | 100.00 | |
| 1911 | 30 | Jan 21 | Jan 21 | 100.00 | |
| 1911 | 31 | Jan 22 | Jan 22 | 100.00 | |
| 1911 | 32 | Jan 23 | Jan 23 | 100.00 | |
| 1911 | 33 | Jan 24 | Jan 24 | 100.00 | |
| 1911 | 34 | Jan 25 | Jan 25 | 100.00 | |
| 1911 | 35 | Jan 26 | Jan 26 | 100.00 | |
| 1911 | 36 | Jan 27 | Jan 27 | 100.00 | |
| 1911 | 37 | Jan 28 | Jan 28 | 100.00 | |
| 1911 | 38 | Jan 29 | Jan 29 | 100.00 | |
| 1911 | 39 | Jan 30 | Jan 30 | 100.00 | |
| 1911 | 40 | Jan 31 | Jan 31 | 100.00 | |
| 1911 | 41 | Feb 1 | Feb 1 | 100.00 | |
| 1911 | 42 | Feb 2 | Feb 2 | 100.00 | |
| 1911 | 43 | Feb 3 | Feb 3 | 100.00 | |
| 1911 | 44 | Feb 4 | Feb 4 | 100.00 | |
| 1911 | 45 | Feb 5 | Feb 5 | 100.00 | |
| 1911 | 46 | Feb 6 | Feb 6 | 100.00 | |
| 1911 | 47 | Feb 7 | Feb 7 | 100.00 | |
| 1911 | 48 | Feb 8 | Feb 8 | 100.00 | |
| 1911 | 49 | Feb 9 | Feb 9 | 100.00 | |
| 1911 | 50 | Feb 10 | Feb 10 | 100.00 | |
| 1911 | 51 | Feb 11 | Feb 11 | 100.00 | |
| 1911 | 52 | Feb 12 | Feb 12 | 100.00 | |
| 1911 | 53 | Feb 13 | Feb 13 | 100.00 | |
| 1911 | 54 | Feb 14 | Feb 14 | 100.00 | |
| 1911 | 55 | Feb 15 | Feb 15 | 100.00 | |
| 1911 | 56 | Feb 16 | Feb 16 | 100.00 | |
| 1911 | 57 | Feb 17 | Feb 17 | 100.00 | |
| 1911 | 58 | Feb 18 | Feb 18 | 100.00 | |
| 1911 | 59 | Feb 19 | Feb 19 | 100.00 | |
| 1911 | 60 | Feb 20 | Feb 20 | 100.00 | |
| 1911 | 61 | Feb 21 | Feb 21 | 100.00 | |
| 1911 | 62 | Feb 22 | Feb 22 | 100.00 | |
| 1911 | 63 | Feb 23 | Feb 23 | 100.00 | |
| 1911 | 64 | Feb 24 | Feb 24 | 100.00 | |
| 1911 | 65 | Feb 25 | Feb 25 | 100.00 | |
| 1911 | 66 | Feb 26 | Feb 26 | 100.00 | |
| 1911 | 67 | Feb 27 | Feb 27 | 100.00 | |
| 1911 | 68 | Feb 28 | Feb 28 | 100.00 | |
| 1911 | 69 | Feb 29 | Feb 29 | 100.00 | |
| 1911 | 70 | Mar 1 | Mar 1 | 100.00 | |
| 1911 | 71 | Mar 2 | Mar 2 | 100.00 | |
| 1911 | 72 | Mar 3 | Mar 3 | 100.00 | |
| 1911 | 73 | Mar 4 | Mar 4 | 100.00 | |
| 1911 | 74 | Mar 5 | Mar 5 | 100.00 | |
| 1911 | 75 | Mar 6 | Mar 6 | 100.00 | |
| 1911 | 76 | Mar 7 | Mar 7 | 100.00 | |
| 1911 | 77 | Mar 8 | Mar 8 | 100.00 | |
| 1911 | 78 | Mar 9 | Mar 9 | 100.00 | |
| 1911 | 79 | Mar 10 | Mar 10 | 100.00 | |
| 1911 | 80 | Mar 11 | Mar 11 | 100.00 | |
| 1911 | 81 | Mar 12 | Mar 12 | 100.00 | |
| 1911 | 82 | Mar 13 | Mar 13 | 100.00 | |
| 1911 | 83 | Mar 14 | Mar 14 | 100.00 | |
| 1911 | 84 | Mar 15 | Mar 15 | 100.00 | |
| 1911 | 85 | Mar 16 | Mar 16 | 100.00 | |
| 1911 | 86 | Mar 17 | Mar 17 | 100.00 | |
| 1911 | 87 | Mar 18 | Mar 18 | 100.00 | |
| 1911 | 88 | Mar 19 | Mar 19 | 100.00 | |
| 1911 | 89 | Mar 20 | Mar 20 | 100.00 | |
| 1911 | 90 | Mar 21 | Mar 21 | 100.00 | |
| 1911 | 91 | Mar 22 | Mar 22 | 100.00 | |
| 1911 | 92 | Mar 23 | Mar 23 | 100.00 | |
| 1911 | 93 | Mar 24 | Mar 24 | 100.00 | |
| 1911 | 94 | Mar 25 | Mar 25 | 100.00 | |
| 1911 | 95 | Mar 26 | Mar 26 | 100.00 | |
| 1911 | 96 | Mar 27 | Mar 27 | 100.00 | |
| 1911 | 97 | Mar 28 | Mar 28 | 100.00 | |
| 1911 | 98 | Mar 29 | Mar 29 | 100.00 | |
| 1911 | 99 | Mar 30 | Mar 30 | 100.00 | |
| 1911 | 100 | Mar 31 | Mar 31 | 100.00 | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03313 | | | | | |
|--|--|--|--|---|--|--|--|---|--|--|--|--|--|---------------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 1. DECEASED NAME (TYPE OR PRINT) <u>Wade E. Pusey</u> | | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR <u>January 10, 1981</u> | | 2b. HOUR <u>8:00</u> P.M. | |
| 3. SEX <u>MALE</u> | | 4. RACE <u>WHITE</u> | | 5. DATE OF BIRTH MONTH DAY YEAR <u>MAY 31, 1907</u> | | 6. AGE (IN YEARS LAST BIRTHDAY) <u>73</u> YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) <u>MD.</u> | | 7b. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH <u>Wicomico</u> MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH <u>Salisbury</u> | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) <u>Peninsula General Hospital</u> | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) <u>RETIRED</u> | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |
| 13a. STATE <u>MD.</u> | | 13b. COUNTY <u>WICOMICO</u> | | 13c. CITY OR TOWN <u>SALISBURY</u> | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS <u>522 WINDER ST.</u> | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST <u>EDGER PUSEY</u> | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST <u>ANNIE TAYLOR</u> | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) <u>NO</u> | | 16b. SOCIAL SECURITY NO. <u>214-10-6548</u> | | 17. INFORMANT ADDRESS <u>MRS NELLIE PUSEY SALISBURY, MD.</u> | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiopulmonary Arrest</u> <u>4292</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Renal Failure</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Atherosclerotic Cardiovascular Disease</u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebrovascular Accident</u> | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. <u>19</u> | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from <u>12/30</u> , 19 <u>80</u> , to <u>1/10</u> , 19 <u>81</u> , that (1) (we) last saw the deceased alive on <u>1/10</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | | | DEGREE <u>M.D.</u> ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | | | 22c. DATE SIGNED <u>1/10/81</u> | | | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>Robert Reilly M.D.</u> | | | | 22e. ADDRESS <u>Peninsula Gen. Hospital, Salisbury, Md.</u> <u>21801</u> | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>BURIAL</u> | | 23b. DATE <u>1/13/80</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>SPRING HILL MEM.</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>SALISBURY, MD.</u> | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME <u>LEVIN R. WILSON</u> ADDRESS <u>SALISBURY, MD.</u> | | | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 13 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>[Signature]</u> | | | | | | | | | |

Wichita

Salisbury

SS

Wichita

Wichita

Wichita

Wichita

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|---|--|--|--|---|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. 03314 | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST ANNA M QUILLEN | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1-8-81 | | | 2b. HOUR MIN 1:15 PM | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR 6-11-1893 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 87 | | 7. IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 8 BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 9 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10 CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Wicomico Nursing Home | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13b. STATE 13c. CITY OR TOWN Md. Wicomico Salisbury | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 1300 Emerson Ave. | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Thomas Savage | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ann Fisher | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 212 14 4091 | | 17 INFORMANT ADDRESS Beatrice P. Jefferson, 1300 Emerson Ave, Salisbury, Md. | | |
| 18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cerebrovascular Accident</u> 4360 DUE TO, OR AS A CONSEQUENCE OF (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH _____ | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1a: _____ | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>12-3</u> 19 <u>80</u> to <u>1-8</u> 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1-7</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE <u>A.C. Hitchell</u> DEGREE _____ | | | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED <u>12-9-81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) A.C. Hitchell, M.D. | | | | | 22e. ADDRESS POB2378 Salisbury, Md | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | 23b. DATE 1/12/81 | | 23c. NAME OF CEMETERY OR CREMATORY Odd Fellows | | 23d. LOCATION CITY OR TOWN COUNTY STATE Milford Kent Del. | | |
| 24. FUNERAL DIRECTOR (NAME) William Hays | | | | | ADDRESS Milford Del. | | 25a. DATE REC'D. BY REGISTRAR FEB 3 1981 | | |
| | | | | | | | 25b. REGISTRAR'S SIGNATURE [Signature] | | |

BP _____

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at the time of death.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|---|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | | REG. NO. | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | 2a. DATE OF DEATH | | MONTH DAY YEAR | | 2b. HOUR | |
| George W. Reid | | | | 1-28-81 | | 11:30AM | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. IF UNDER 1 YEAR | |
| M | | W | | MONTH DAY YEAR | | 79 YRS. | | MONTHS DAYS HOURS MIN. | |
| 8. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 9. CITIZEN OF WHAT COUNTRY? | | 10. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> | | 11. BALTIMORE CITY OR COUNTY OF DEATH | | | |
| Maryland | | USA | | WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | Wicomico County | | MD. | |
| 12. CITY OR TOWN OF DEATH | | 13. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION | | 14. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 15. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Salisbury Nursing Home | | retired Store Keeper | | | | | |
| 16. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | 17. STATE | | 18. COUNTY | | 19. CITY OR TOWN | | 20. INSIDE CITY LIMITS? | |
| Maryland | | Worcester | | Pocomoke | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 21. STREET ADDRESS | |
| 22. FATHER'S NAME | | 23. MOTHER'S MAIDEN NAME | | 24. ADDRESS | | 25. STREET ADDRESS | | | |
| Elton James Reid | | Mary V. Taylor | | 210 Walnut Street | | 210 Walnut Street | | | |
| 26. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 27. SOCIAL SECURITY NO. | | 28. INFORMANT | | 29. ADDRESS | | | |
| no | | 214-32-6844 | | Virgie Reid | | 210 Walnut Street | | | |
| 30. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | 31. PART 1: DEATH WAS CAUSED BY | | 32. IMMEDIATE CAUSE (a) | | 33. DUE TO, OR AS A CONSEQUENCE OF | | 34. APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| 4340 | | Cerebral Thrombosis | | (b) generalized arteriosclerosis | | (c) | | 1 day | |
| Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | 35. PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | |
| 36. DATE OF OPERATION | | 37. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 38. AUTOPSY? | | 39. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22. I certify that (I) (this hospital) attended the deceased from 4/13, 1979, to 4/28, 1981, that (I) (we) last saw the deceased alive on 4/28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | 23. SIGNATURE | | 24. DEGREE | | 25. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 26. DATE SIGNED | |
| DR. EARL M. BEARDSLEY | | CIVIC AVE, RT 50, SALISBURY, MD. 21801 | | | | | | 1/29/81 | |
| 27. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 28. DATE | | 29. NAME OF CEMETERY OR CREMATORY | | 30. LOCATION CITY OR TOWN COUNTY STATE | | | |
| Burial | | 1/31/81 | | Remson Meth. Cem. | | Pocomoke Worcester Md. | | | |
| 31. FUNERAL DIRECTOR NAME | | 32. ADDRESS | | 33. DATE REC'D. BY REGISTRAR | | 34. REGISTRAR'S SIGNATURE | | | |
| Scott S. Nelson | | Pocomoke City, Md. | | FEB 4 1981 | | | | | |

Refined State

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03316 | | | |
|---|--|---|--|---|--|---|--|--|--|-----------------------------------|-----------|--|--------------------------|
| 1. FOR STATE REGISTRAR | | REG. NO. | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST FANNIE | | MIDDLE L. | | LAST Scheck | | 2a. DATE OF DEATH | | MONTH JANUARY | DAY 19 | YEAR 1981 | 2b. HOUR 5:42 A.M. |
| 3. SEX Female | | 4. RACE white | | 5. DATE OF BIRTH MONTH 1 / DAY 30 / YEAR 04 | | 6. AGE (IN YEARS LAST BIRTHDAY) 76 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE RESIDENCE BEFORE ADMISSION) Peninsula General Hospital | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | 13b. COUNTY | | 13c. CITY OR TOWN BALTIMORE | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 6718 Beentwood Ave | | | | | |
| 14. FATHER'S NAME FIRST John MIDDLE COLLINS LAST | | 15. MOTHER'S MAIDEN NAME FIRST Rose MIDDLE UNKNOWN LAST | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 233-30-5146 | | 17. INFORMANT ADDRESS Pauline Krause Same As 13 | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hyperosmolar Coma</u> <u>2502</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Sepsis</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>Shock</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET | | CITY OR TOWN | | COUNTY | | STATE | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1/17/81</u> , 19 <u>81</u> , to <u>1/18/81</u> , 19 <u>81</u> , that (I) (we) lost saw the deceased alive on <u>1/18/81</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE <u>[Signature]</u> | | DEGREE | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | | 22c. DATE SIGNED 1/20-81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. G. Ruffe Ho | | 22e. ADDRESS PGH | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 1/23/81 | | 23c. NAME OF CEMETERY OR CREMATORY L.O.O.F. Cemetery | | 23d. LOCATION CITY OR TOWN Baltimore | | COUNTY Baltimore | | STATE Md. | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds | | ADDRESS Salisbury, Md | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | | | | |



Handwritten text, possibly a signature or name, located in the upper right area of the page.

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03317

1. FOR
STATE
REGISTRAR

| | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) Annie Allen Selby | | | 2a. DATE OF DEATH MONTH DAY YEAR January 27, 1981 | | | 2b. HOUR 5:15 PM | | | |
| 3. SEX Female | | 4. RACE Negro | | 5. DATE OF BIRTH MONTH DAY YEAR June 15, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Md. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Laborer | | 12b. KIND OF BUSINESS OR INDUSTRY Factory | |
| 13a. STATE Md. | | 13c. CITY OR TOWN Worcester Pocomoke | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 13e. STREET ADDRESS Rt. 3 Bx. 245 | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST George Richards | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Unk. | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 219-07-6945 | | 17. INFORMANT ADDRESS Isabelle Revels P.O. Bx. 244 Pocomoke, Md. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Respiratory Insufficiency secondary DUE TO, OR AS A CONSEQUENCE OF (b) to lung metastasis from Breast Carcinoma DUE TO, OR AS A CONSEQUENCE OF (c) 1749 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (I) (the hospital) attended the deceased from 1/25 , 19 81 , to 1/27 , 19 81 , that (I) (we) last saw the deceased alive on 1/27 , 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Joseph N. Grasso | | | DEGREE MD | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 1/27/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Joseph N. Grasso | | | 22e. ADDRESS 1300 S. Division St Bar. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (CHECK ONE) Burial | | | 23b. DATE 1-30-81 | | 23c. NAME OF CEMETERY OR CREMATORY Family Plot Cem. Pocomoke | | 23d. LOCATION CITY OR TOWN COUNTY STATE Pocomoke Wic. Md. | | |
| 24. FUNERAL DIRECTOR NAME Samuel Lee | | | ADDRESS New Church, Va. | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE Jeffrey McCreedy | | |

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Information

Sanitary Department General Hospital

Sanitary Department General Hospital

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IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

1. FOR
STATE
REGISTRAR

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03318

| | | | | | |
|---|--|---|---|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) BERYL MACLEAN SHARRAR | | | 2a. DATE OF DEATH MONTH 1 / DAY 1 / YEAR 81 | | 2b. HOUR 8⁵⁰ P.M. |
| SEX Female | 4. RACE White | 5. DATE OF BIRTH MONTH Aug / DAY 23 / YEAR 1897 | 6. AGE (IN YEARS LAST BIRTHDAY) 83 | | IF UNDER 1 YEAR MONTHS / DAYS / HOURS / MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Colorado | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 1527 WOODLAND RD | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) House Wife | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | |
| 13a. STATE MARYLAND | | 13b. COUNTY Wicomico | 13c. CITY OR TOWN SALISBURY | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 13e. STREET ADDRESS 1527 WOODLAND RD. |
| 14. FATHER'S NAME FIRST NEIL MIDDLE MAC LEAN LAST MAC LEAN | | 15. MOTHER'S MAIDEN NAME FIRST SADIE MIDDLE MAC DOWELL LAST MAC DOWELL | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) No | | 16b. SOCIAL SECURITY NO. 214-74-4196 | | 17. INFORMANT ADDRESS DEAN L. SHARRAR See Sec 13 | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Thrombosis 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Cerebral Arteriosclerosis 20 yrs.- (c) | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 hours |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1: | | | | | |
| 19a. DATE OF OPERATION 9/9/81 | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (the hospital) attended the deceased from March 7 , 19 63 , to Jan 1 , 19 81 , that (I) was last saw the deceased alive on Jan 1 , 19 81 , and that in (my) own opinion death occurred on the date and hour and from the causes stated above, (I) do (did) (do not) view the body after death. | | | | | |
| 22b. SIGNATURE Thomas C Hill Jr MD | | | | 22c. DATE SIGNED 1/1/81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Dr Thomas C. Hill Jr | | | | 22e. ADDRESS Pine Bluff Rd Salis | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Cremation | | 23b. DATE 1/2/81 | | 23c. NAME OF CEMETERY OR CREMATORY DelmarVA Crematory | |
| 24. FUNERAL DIRECTOR NAME Hill-BAKEN-BOUNDS ADDRESS SALISBURY, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 6 1981 | | | |

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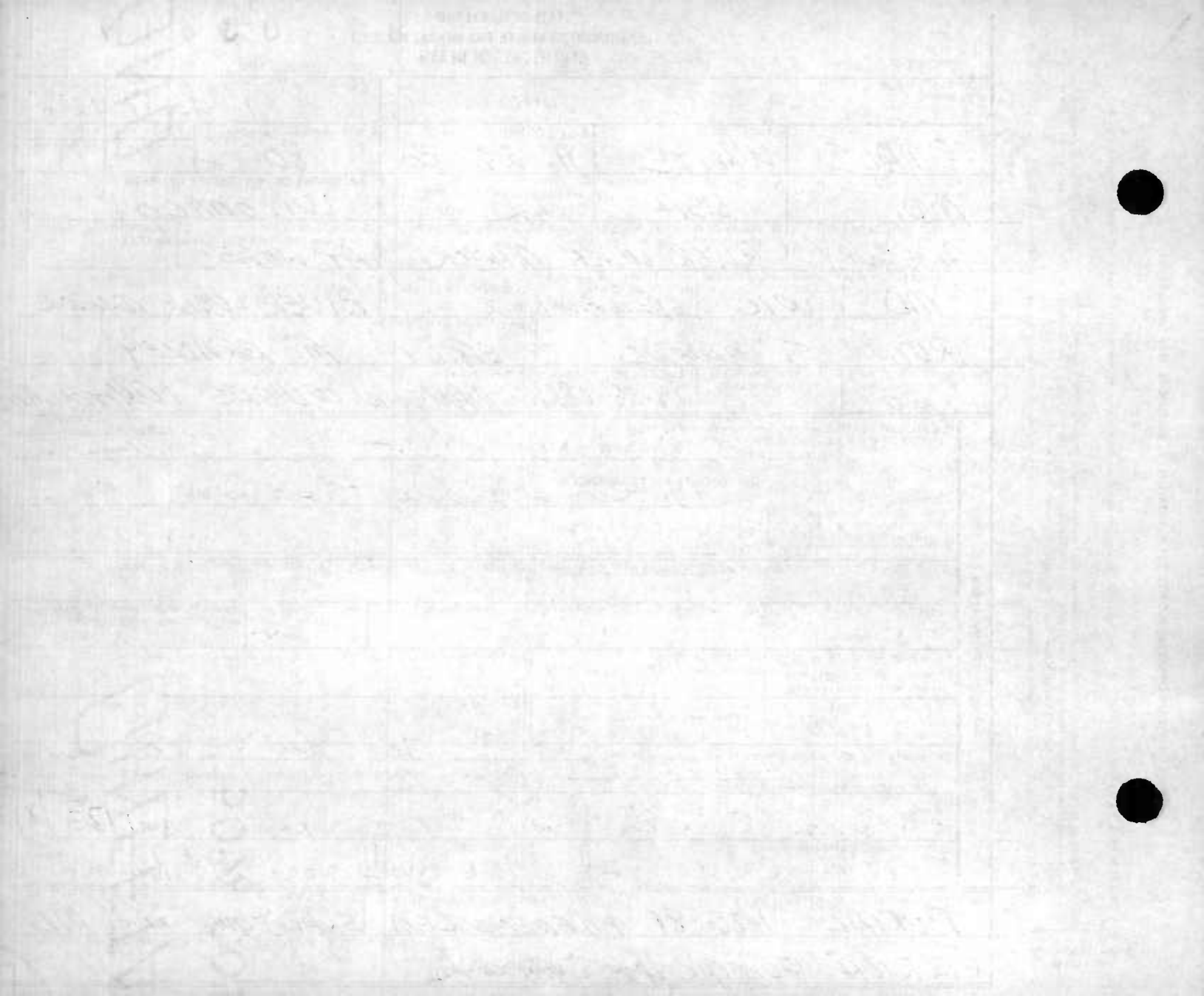
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MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03319 | |
|---|--|---|--|---|--|--|--|--|--|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST SARAH O SHIELDS | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 23 81 | | | | 2b. HOUR 12 ³⁰ P M | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR 11-29-00 | | 6. AGE (IN YEARS LAST BIRTHDAY) 80 YRS. | | 7. IF UNDER 1 YEAR MONTHS DAYS | | 7. IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WILCOMICO MD. | | | | | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) RIVER WALK MANOR | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) AT HOME | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| 13a. STATE MD | | | | | | 13b. COUNTY WIC | | 13c. CITY OR TOWN SALISBURY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 14. FATHER'S NAME FIRST MIDDLE LAST IRVIN S. OWENS | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SAKLY M. BRADLEY | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 28-58-0837 | | 17. INFORMANT ADDRESS MANSON OWENS - WILCOMICO, MD. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 4140 Cardiac Arrest DUE TO, OR AS A CONSEQUENCE OF (b) Chronic sclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) 1 year Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that this hospital attended the deceased from Aug 9 19 78, to Jan 23 19 81, that (he)(we) last saw the deceased alive on Jan 23 19 81, and that in (my)(our) opinion death occurred on the date and hour and from the causes stated above, (we) did (not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Thomas C Hill Jr M.D. | | | | | | DEGREE M.D. | | 22c. DATE SIGNED 1/23/81 | | 22d. ADDRESS Pine Bluff Road, Salisbury, MD. | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | | | 23b. DATE 1-26-81 | | 23c. NAME OF CEMETERY OR CREMATORY FIREMEN'S CEM | | 23d. LOCATION CITY OR TOWN COUNTY STATE SHARPTOWN WIC MD | |
| 24. FUNERAL DIRECTOR NAME ULLRICH FUNERAL HOME | | | | | | ADDRESS SHARPTOWN | | 25. DATE REC'D. BY REGISTRAR 1-26-81 | | 25b. REGISTRAR'S SIGNATURE | |

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| 1. FOR STATE REGISTRAR | | STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | 0 3 3 2 0 | | | |
|--|--|---|--|---|--|--|--|
| REG. NO. | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST HERBERT A. SKINNER | | | | 2a. DATE OF DEATH MONTH DAY YEAR 1 25 81 | | 2b. HOUR 3 P.M. | |
| 3. SEX MALE | | 4. RACE N | | 5. DATE OF BIRTH 10th 18 YE 44 | | 6. AGE (IN YEARS LAST BIRTHDAY) 66 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO | |
| 10. CITY OR TOWN OF DEATH SALISBURY | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION SALETSBURY NURSING HOME | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) CONSTRUCTION | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD. | | | | 13b. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13c. RT/1 ADDRESS BOX 183 | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Percy Thomas | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ella Skinner Baynum | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) Yes | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) WWII | | 17. INFORMANT ADDRESS Rhodesdale, Md. | | | |
| 16a. Yes | | 16b. 217-01-1614 | | 17. Mrs. Alice Jones, Rt. 1, Box 183, 21659 | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Died of Yaws 4340 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Generalized arteriosclerosis (c) Due to, or as a consequence of | | | | 18. May yes | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) prev. CVA - left hemiparesis | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION CITY OR TOWN COUNTY STATE 1/19 19 79 1/25 19 81 | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/25 19 81 to 1/25 19 81 , that (I) (we) last saw the deceased alive on 1/25 19 81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (to-wit) (did) (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Earl M. Beardsley | | | | 22c. DEGREE MD | | 22d. DATE SIGNED 1/26/81 | |
| 22e. PHYSICIAN'S NAME (TYPE OR PRINT) EARL M. BEARDSLEY, MD. | | | | 22f. ADDRESS U.S. 50-CIVIC AVE., SALISBURY, MD. 21801 | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE Jan. 30, 1981 | | 23c. NAME OF CEMETERY OR CREMATORY Maryland Veterans Cem. | | 23d. LOCATION CITY OR TOWN COUNTY STATE Beulah, Dorchester, Maryland | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Framptom-Hawkins Funeral Home, 216 N. Main St. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | 25b. REGISTRAR'S SIGNATURE Barry McCreedy | |



WILLIAM



Item 5,6 and 13E G 552 2/27/81 STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

0 3 3 2 1

REG. NO.

FOR
STATE
REGISTRAR

| | | | | | | | | | | | | | | | | | | | |
|--|---------|--|--|---|--|--|--|---|--|--------------------------------|--|--|--|------|--|---|--|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | | MIDDLE | | LAST | | 2a. DATE KNOWN OF ESTI- MATED | | MONTH | | DAY | | YEAR | | 2b. HOUR | | | |
| VIOLA B. SMITH | | | | | | | | <input checked="" type="checkbox"/> 1-16-81 | | 19 | | 6 | | | | 30P M | | | |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE | | IF UNDER 1 YR. | | IF UNDER 24 HRS. | | 7c. DATE PRONOUNCED DEAD | | MONTH | | DAY | | YEAR | | 2d. HOUR | |
| Female | White | 12 14 1897 | | 96 81 | | MONTHS DAYS | | HOURS MIN. | | 1-16-81 | | 19 | | | | | | 11 M | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | | | | | | | | |
| Maryland | | USA | | Wicomico MD. | | | | | | | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | | | | | | | | | | | | | | |
| Salisbury | | Peninsula General Hospital | | | | | | | | | | | | | | | | | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | |
| At Home | | | | | | | | | | | | | | | | | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS | | | | | | | | | | | |
| Md. | | Worcester | | Ocean City | | | | 401 N. Balto, Ave. 410 Baltimore Ave. | | | | | | | | | | | |
| 14. FATHER'S NAME | | | | 15. MOTHER'S MAIDEN NAME | | | | | | | | | | | | | | | |
| FIRST MIDDLE LAST | | | | FIRST MIDDLE LAST | | | | | | | | | | | | | | | |
| Henry J. Godfrey | | | | Dora E. Fooks Godfrey | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) | | | | 16b. SOCIAL SECURITY NO. | | | | 17. INFORMANT ADDRESS | | | | | | | | | | | |
| No | | | | 213-74-1203 | | | | Clyde Smith Ocean City, Md. | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: | | | | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| IMMEDIATE CAUSE (a) ASCVD | | | | | | | | | | | | | | | | | | years | |
| 4292 } DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| Conditions, if any, which gave rise to immediate cause (a) stating the under- lying cause last. | | | | | | | | | | | | | | | | | | | |
| (b) DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | | | | | | | | | | |
| (c) | | | | | | | | | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | | | 20. AUTOPSY? | | | |
| | | | | | | | | | | | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| | | | | | | | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE | | | | TITLE (SPECIFY) Deputy | | | | DATE SIGNED | | | | 1-19-81 | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) | | | | ADDRESS | | | | | | | | | | | | | | | |
| Earl L. Royer, M.D. | | | | 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (S/F) | | | | 23b. DATE | | | | 23c. NAME OF CEMETERY OR CREMATORY | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | | | | |
| Burial | | | | 1-20-81 | | | | Sunset Memorial Park | | | | Berlin, Worcester, Md. | | | | | | | |
| 24. FUNERAL DIRECTOR NAME | | | | ADDRESS | | | | 25a. DATE REC'D. BY REGISTRAR | | | | 25b. REGISTRAR'S SIGNATURE | | | | | | | |
| Ullrich Funeral Home, Berlin, Md. | | | | | | | | JAN 26 1981 | | | | Pitney McCurdy | | | | | | | |

DIVISION OF VITAL RECORDS, 301 W. PRESTON ST., BALTIMORE, MD. 21201

BP

DHMH - 17
(VFR A15 ME (5))
15M 7/76

TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PA 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 72 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.



STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03322

1- FOR
STATE
REGISTRAR

| | | | | | | | |
|---|--|--|---|---|--------------------------------------|---|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST JOHN T STEVENSON | | | 2a. DATE OF DEATH MONTH DAY YEAR JANUARY 14 1981 | | 2b. HOUR MIN. 3:45 A.M. | | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 4-6-1915 | | 6. AGE (IN YEARS LAST BIRTHDAY) MONTHS DAYS HOURS MIN. 65 YRS. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK OR MOST OF WORKING LIFE) Laborer | |
| 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | | |

| | | | | | |
|--|--|---|--|--|--|
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY CITY OR TOWN MD SOMERSET PR. ANNE | | 13b. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13c. STREET ADDRESS Box 238, Princess Anne | |
| 14. FATHER'S NAME FIRST MIDDLE LAST SCIPIO STEVENSON | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST ADDIE COZZAMAN | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES <input type="checkbox"/> OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. 220-05-0019 | | 17. INFORMANT ADDRESS ELLEN BELL STEVENSON, Box 238 | |

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:

| | | | |
|---|--|--|--|
| IMMEDIATE CAUSE (a) Cardiac Arrest | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | |
| DUE TO, OR AS A CONSEQUENCE OF (b) 4100 Atherosclerotic heart disease | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) severe post multiple myocardial infarction | | | |

PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)

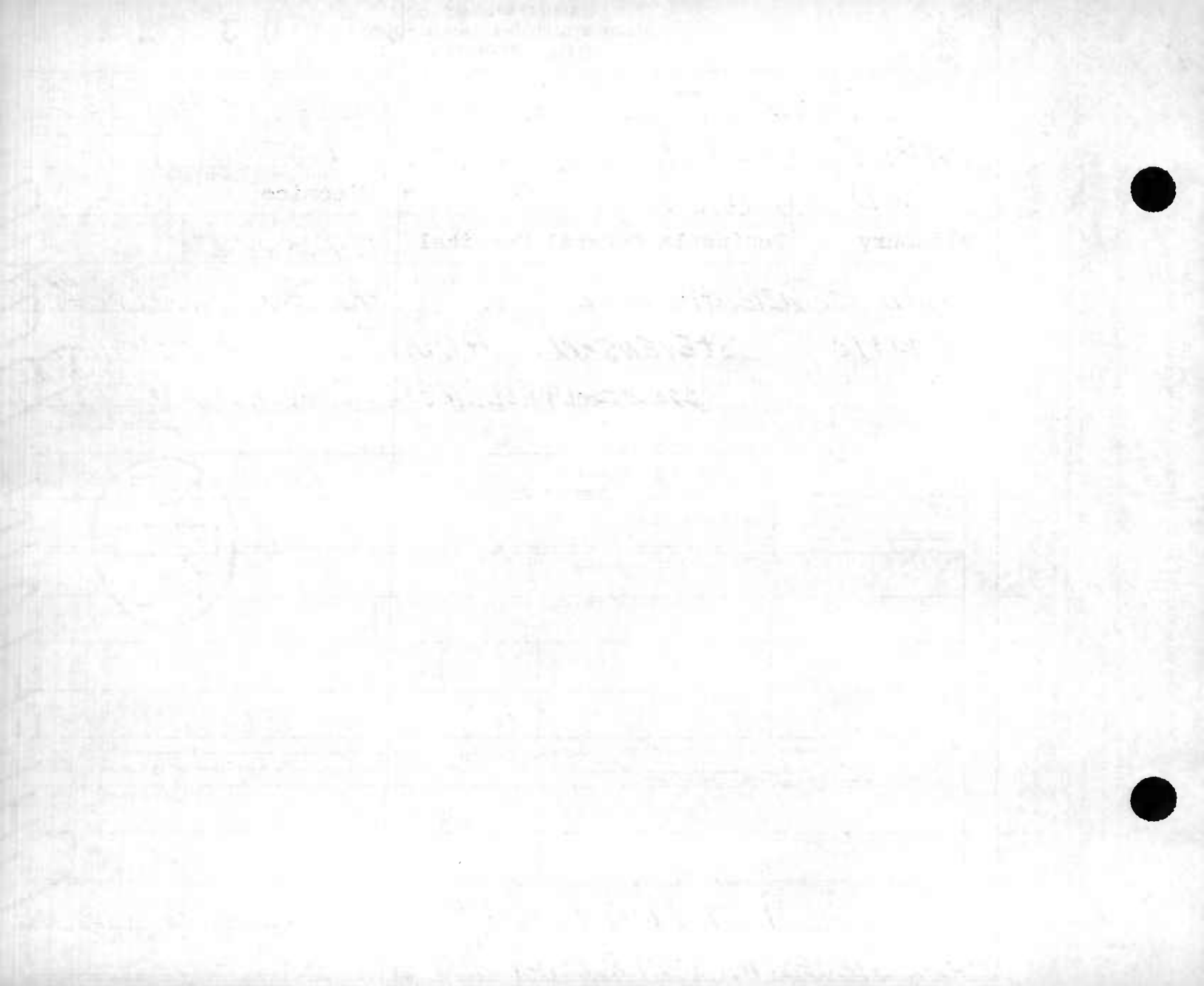
| | | | | | | | |
|---|--|--|--|---|--|--|--|
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18: PART 1 OR PART 2) | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | |
| 22a. I certify that (1) (this hospital) attended the deceased from 1/14/81 , 19____, to _____, 19____, that (1) (we) lost saw the deceased alive on _____, 19____, and that in my (our) opinion death occurred on the date and hour and from the causes stated above (1) (we) did (did not) view the body after death. | | | | | | | |
| 22b. SIGNATURE Clayton Lee Raabomo | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Clayton Lee Raabomo | | | | 22e. ADDRESS Locust & Quincey St Salisbury Md. | | | |

| | | | | | | | |
|--|--|-----------------------------|--|---|--|---|--|
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE 1-17-81 | | 23c. NAME OF CEMETERY OR CREMATORY Mt. HOPE | | 23d. LOCATION CITY OR TOWN COUNTY STATE GREENWOOD SOMERSET, MD | |
| 24. FUNERAL DIRECTOR NAME & ADDRESS ADDIE JAMES HOT SOMERSET AVE PR | | | | 25a. DATE REC'D. BY REGISTRAR JAN 23 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



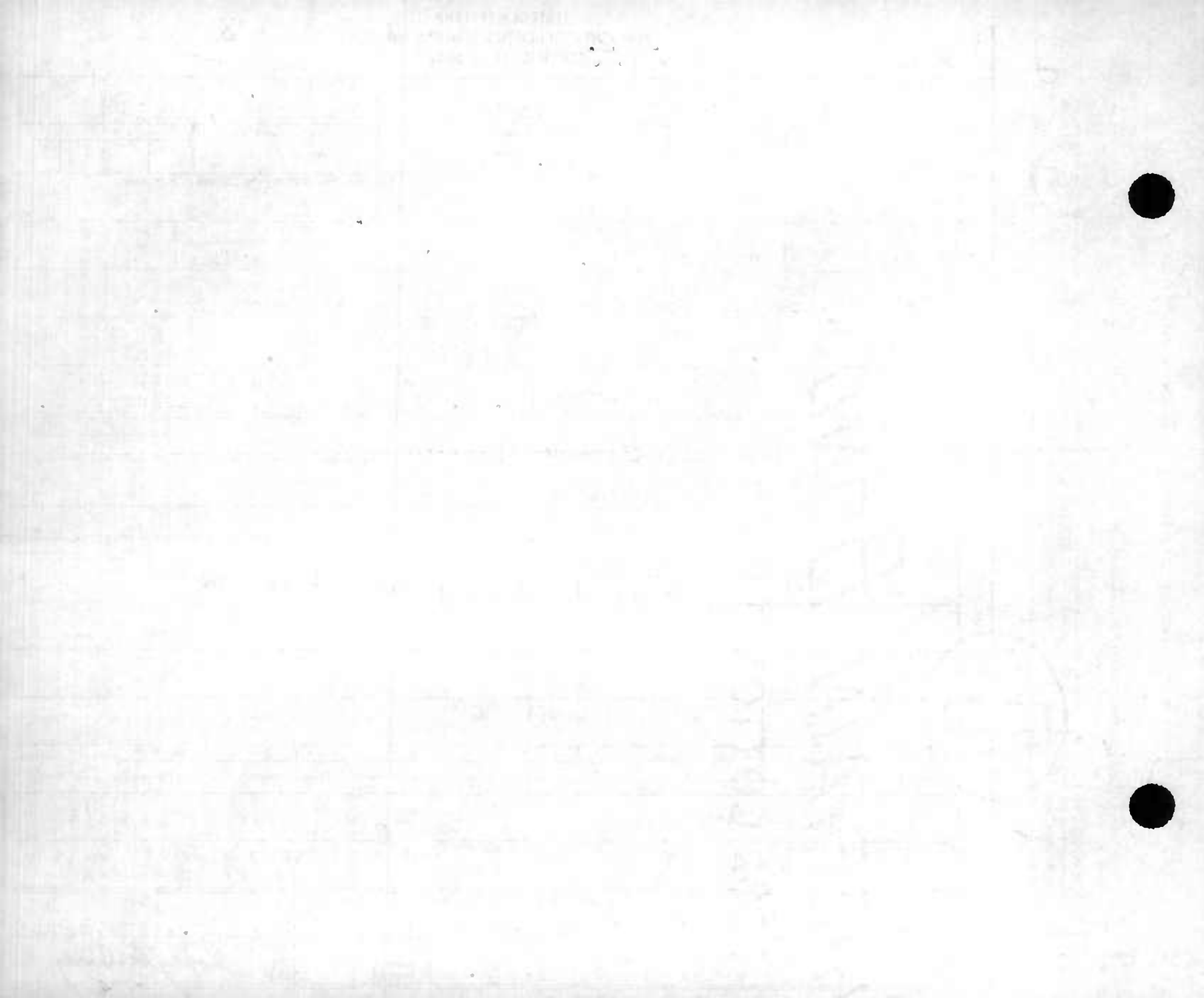
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbonpapers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | |
|---|--|--|-------------------------|---|--------------------------------|--|---|---|---------------------------------------|--|
| 1. FOR STATE REGISTRAR | | REG. NO. 03323 | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Maggie Myrtle Taylor | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 31, 1981 | | 2b. HOUR M | | |
| 3 SEX Female | | 4 RACE White | | 5 DATE OF BIRTH MONTH DAY YEAR Oct. 23, 1897 | | 6 AGE (IN YEARS LAST BIRTHDAY) YRS. 83 | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | 7b. CITIZEN OF WHAT COUNTRY? USA | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9 BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | | |
| 10 CITY OR TOWN OF DEATH Fruitland | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 106 Moore Ave. | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Housewife | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE Maryland | | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Fruitland | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 106 Moore Ave. | |
| 14 FATHER'S NAME FIRST MIDDLE LAST Alexander W. Hopkins | | | | 15 MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Sally A. Jones | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | 16b. SOCIAL SECURITY NO. 218-16-7410 | | 17 INFORMANT (son) 104 Harvest Lane | | 17b. ADDRESS Mr. J. Wayne Taylor, Salisbury, Md. | | | | |
| 18 CAUSE OF DEATH Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) ① <u>OCAREINOMA OF COLON.</u> 1539 DUE TO, OR AS A CONSEQUENCE OF (b) ② <u>ECZEMA.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) C.O.P.D.; Recurrent Urinary tract infection. | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19, 1980, to 11/29, 1980, that (I) (we) last saw the deceased alive on 11/29, 1980, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) not view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE H.R. HIEDA | | | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | 22c. DATE SIGNED 2/5/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) H.R. HIEDA | | | | 22e. ADDRESS 614 C EASTERN SHORE Drive SALISBURY, MD. 21807. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | 23b. DATE 2/3/81 | | 23c. NAME OF CEMETERY OR CREMATORY Siloam Cemetery | | 23d. LOCATION CITY OR TOWN COUNTY STATE Siloam, Wic., Maryland | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | 25a. DATE REC'D. BY REGISTRAR FEB 11 1981 | | 25b. REGISTRAR'S SIGNATURE [Signature] | | | | |

BP



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 24 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE | | | | | | | | | | |
|--|--|--|---|---|--|--|--|--|-----------------------|--|
| 1. FOR STATE REGISTRAR | | | | | 8 1 0 3 3 2 4 REG. NO. | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH MONTH DAY YEAR | | | | | |
| MARY Elizabeth TAYLOR | | | | | JANUARY 28, 1981 | | | | | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7b. HOUR | | |
| Female | | White | | Sept. 19, 1921 | | 59 YRS. | | 2:20p M | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | |
| Maryland | | USA | | | | WICOMICO MD. | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| SALISBURY | | DEER'S HEAD CENTER | | | | Mgr. & owner | | Restaurant | | |
| 13a. STATE | | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. INSIDE CITY LIMITS? | | 13e. STREET ADDRESS | |
| Maryland | | | Wicomico | | Salisbury | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | Rt. 5, Riawakin Drive | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | |
| D. Claud Adkins | | | | | Margaret N. Trader | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) (IF YES, GIVE WAR OR DATES) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | | |
| NO | | | | | 216-14-2129 | | Mrs. Doris L. Keeler, W. Jefferson, W. Va. | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) | | | | | | | | | | |
| PART 1. DEATH WAS CAUSED BY: | | | | | | | | | | |
| IMMEDIATE CAUSE (a) <i>Bronchopneumonia</i> | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (b) _____ | | | | | | | | | | |
| DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>Severe Rheumatoid arthritis</i> | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| | | | P.M. 19 | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| | | | | | | | | | | |
| 22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <i>Sep. 23</i> , 19 <i>80</i> , to <i>Jan. 28</i> , 19 <i>81</i> , that <input checked="" type="checkbox"/> (we) lost saw the deceased alive on <i>Jan. 28</i> , 19 <i>81</i> , and that in <i>my</i> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | | DEGREE | | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | |
| <i>Inja J. Hwang</i> | | | | | | | | 01/29/81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | | | 22e. ADDRESS | | | | | |
| Inja J. Hwang, M.D. | | | | | P. O. Box 2018, Salisbury, Md. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| Burial | | 2/1/81 | | Wicomico Memorial Park, Salisbury, Wic., Md. | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS | | | | | 25a. DATE REC'D. BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | |
| HOLLOWAY FUNERAL HOME, Salisbury, Md. | | | | | FEB 2 1981 | | <i>Jeffrey H. Hwang</i> | | | |

100 2 024

Handwritten signature

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, pages 1 and 2 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified of course.

MEDICAL CERTIFICATION

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 8 1 0 3 3 2 5 | |
|---|--|--|--|---|--|--|--|--|--|------------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) PEARL BOUNDS Towers | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 5, 1981 | | | 2b. HOUR 5¹⁵ PM | | | |
| 3. SEX FEMALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR FEB. 2, 1897 | | 6. AGE (IN YEARS LAST BIRTHDAY) 83 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MARYLAND | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) HOUSEWIFE | | 12b. KIND OF BUSINESS OR INDUSTRY Own Home | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE MD 13b. COUNTY Wicomico 13c. CITY OR TOWN Salisbury | | | | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 202 Naylor St | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST JAMES Edward BOUNDS | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE ANNE Elizabeth KING | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) 212-74-9929 | | 17. INFORMANT ADDRESS MYSTLE A. TOWERS, 202 Naylor St, Salisbury, Md. | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Arrest 4140 DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic Heart Disease DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from August 61 to June 5, 1981 , that (I) (we) lost saw the deceased alive on Dec 15 19 80 , and that in my (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE Thomas C Hill Jr. DEGREE M.D. | | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | 22c. DATE SIGNED 1/5/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) THOMAS C. HILL JR | | | | | 22e. ADDRESS Pine Bluff Road, Salisbury, Md. | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | 23b. DATE 1/7/1981 | | 23c. NAME OF CEMETERY OR CREMATORY Parsons Cem | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico MD | | | | |
| 24. FUNERAL DIRECTOR NAME Hill-Baker-Bounds, Salisbury, Md. | | | | | 25. DATE REC'D. BY REGISTRAR JAN 8 1981 | | REGISTRAR'S SIGNATURE <i>[Signature]</i> | | | | |



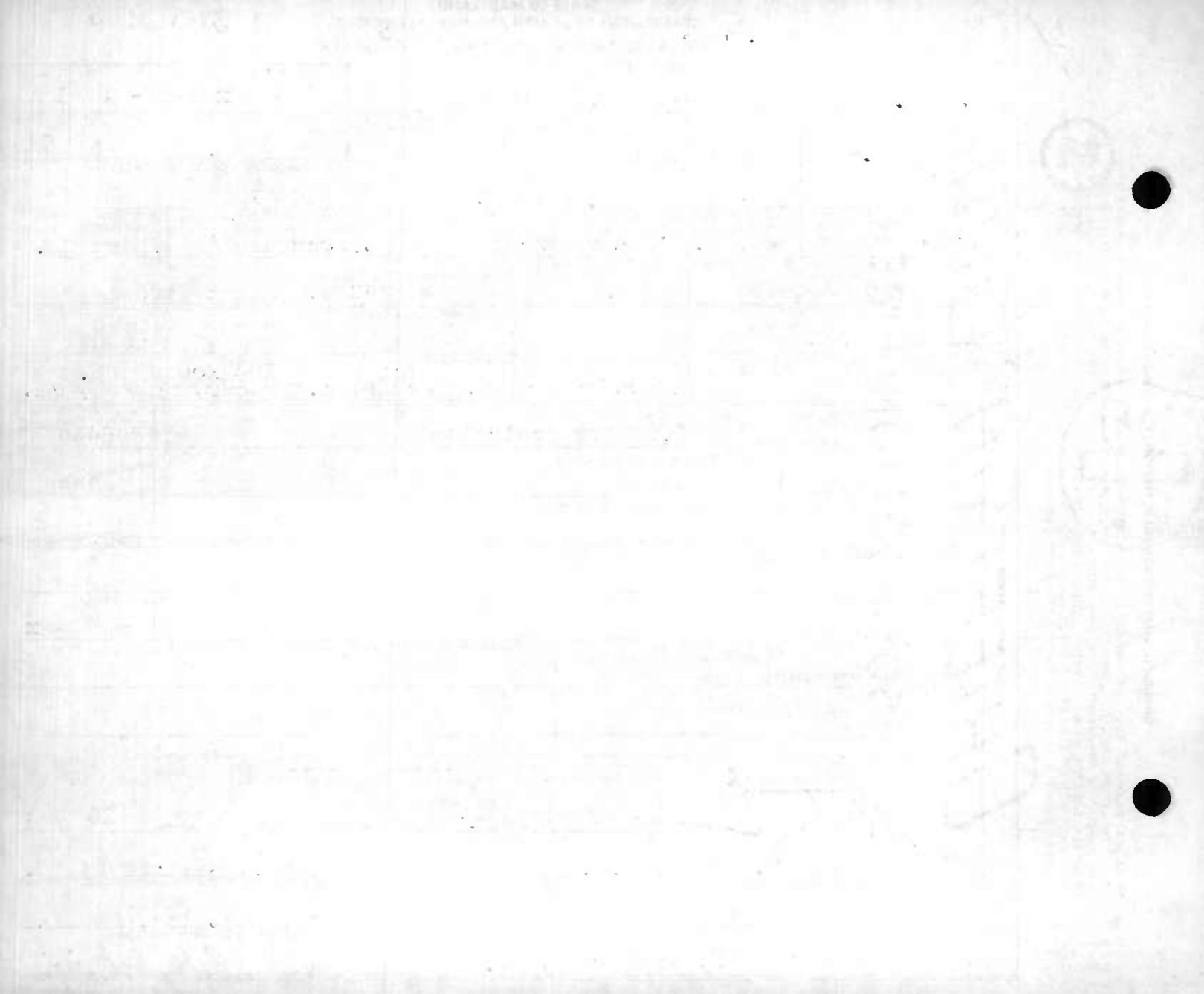
Instruction General Horizontal



TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 18. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER ALONG WITH FORM PM 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL-TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITHIN 24 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP
DHMH - 17
(VR A15 ME (5))
30M 7/73

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | 0 3 3 2 6 REG. NO. | |
|---|--|-------------------------|--|--|--|--|--|---|--|--|--|---|--|--|--|--|--|--|--|-----------------------|--|
| 1. DECEASED NAME (TYPE OR PRINT) FIRST MIDDLE LAST Mildred Bennett Trader | | | | | | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-23-81 | | | | | | | | | | 2b. HOUR 1 A.M. | |
| 3. SEX Female | | 4. RACE White | | 5. DATE OF BIRTH MONTH DAY YEAR May 17, 1899 | | 6. AGE (IN YEARS) LAST BIRTHDAY 81 YRS. | | IF UNDER 1 YR. MONTHS DAYS HOURS MIN | | 7c. DATE PRONOUNCED DEAD Jan. 23 19 81 | | 2d. HOUR 9 A.M. | | | | | | | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Maryland | | | | 7b. CITIZEN OF WHAT COUNTRY? USA | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH WICOMICO MD. | | | | | | | | | |
| 10. CITY OR TOWN OF DEATH Hebron | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) 402 E. Walnut Street | | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) Seamstress | | | | 12b. KIND OF BUSINESS OR INDUSTRY Shirt Co. | | | | | | | |
| USUAL RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | | | | | | | | | | | | | |
| 13a. STATE Maryland | | 13b. COUNTY Wicomico | | 13c. CITY OR TOWN Hebron | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 402 E. Walnut Street | | | | | | | | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Orietus Wilton Owens | | | | | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Josephine (unknown) | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) No | | | | 16b. SOCIAL SECURITY NO. 216-07-6299 | | 17. INFORMANT (son) ADDRESS 104 Howard St. Mr. Charles W. Trader, Hebron, Md. | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 4100 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost. (b) <u>ASCVD</u> (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | | | |
| 22a. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/> . | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <i>Earl L. Royer</i> | | | | | | | | | | TITLE (SPECIFY) M.D. Deputy MEDICAL EXAMINER | | | | | | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Royer, M.D. | | | | | | | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY Hebron Cemetery | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Hebron, Wicomico, Maryland | | | | | | | | | | | |
| 24. FUNERAL DIRECTOR NAME HOLLOWAY FUNERAL HOME, ADDRESS Salisbury, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR JAN 27 1981 | | | | | | | | | | | |
| | | | | | | | | | | 25b. REGISTRAR'S SIGNATURE <i>Rickey McCreedy</i> | | | | | | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon copiers. Pages 1 and 2 should be filed within 10 days after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

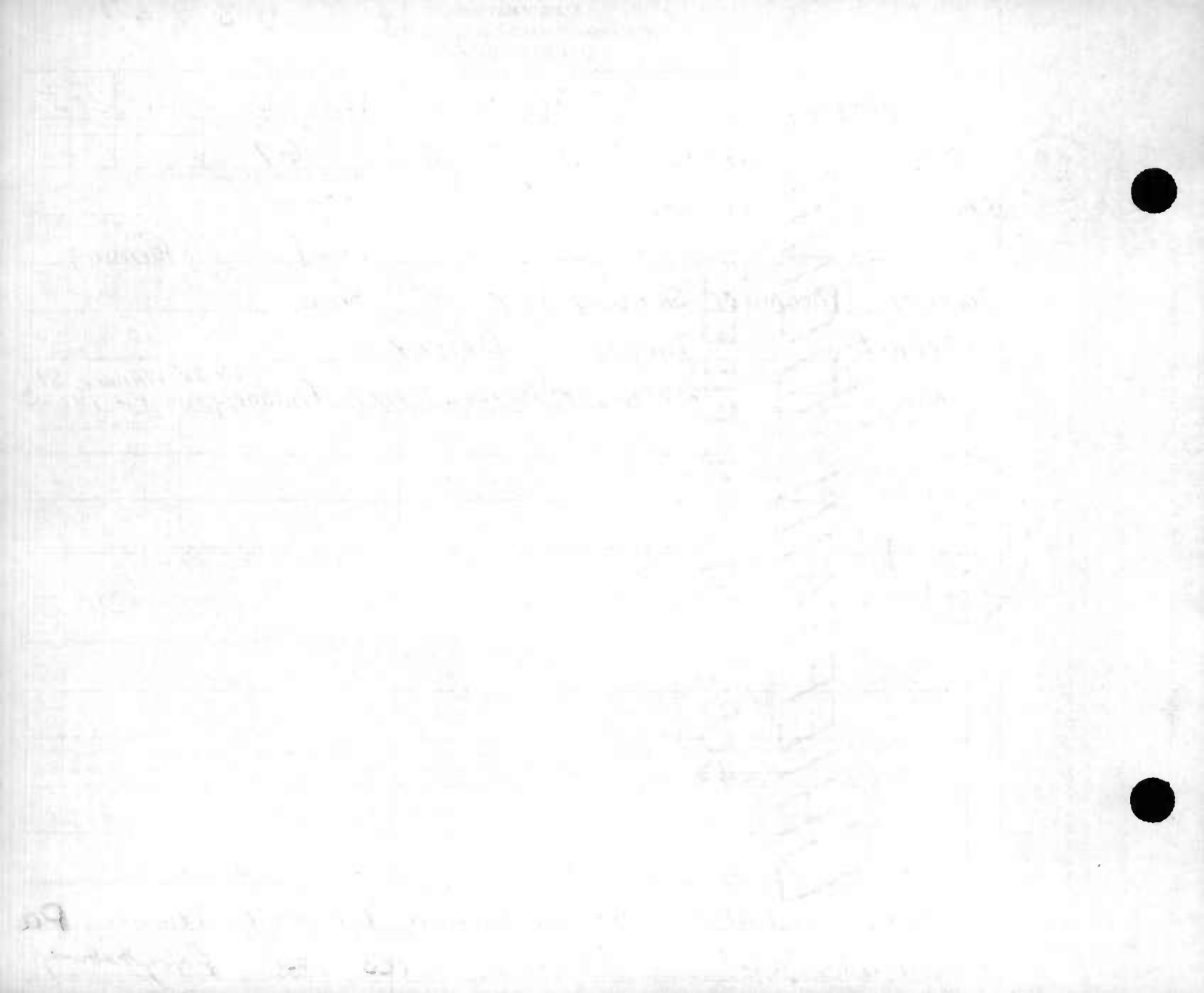
03321

| | | | | | | | | | | | |
|---|--|--|--|--|--|---|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | 2a. DATE OF DEATH | | | MONTH DAY YEAR | | | 2b. HOUR | | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | FIRST MIDDLE LAST | | | JANUARY 29, 1981 | | | 3 52 A M | | |
| 3. SEX | | | 4. RACE | | | 5. DATE OF BIRTH | | | 6. AGE (IN YEARS LAST BIRTHDAY) | | |
| MALE | | | NEGRO | | | 11 10 13 | | | 67 YRS. | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | | 7b. CITIZEN OF WHAT COUNTRY? | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | |
| Baltimore, Md | | | U.S.A. | | | | | | Wicomico MD. | | |
| 10. CITY OR TOWN OF DEATH | | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | |
| Salisbury | | | Peninsula General Hospital | | | retired | | | farming | | |
| 13a. STATE | | | 13b. CITY OR TOWN | | | 13c. INSIDE CITY LIMITS? | | | 13d. STREET ADDRESS | | |
| MARYLAND | | | Wicomico | | | YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | Rose | | |
| 14. FATHER'S NAME | | | 15. MOTHER'S MAIDEN NAME | | | 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | 16b. SOCIAL SECURITY NO. | | |
| Michael | | | DAISEY | | | NO | | | 217-05-5179 | | |
| 17. INFORMANT | | | ADDRESS | | | 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c) | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | |
| Michael Turner | | | 1028 Wallace St Philadelphia, Pa 19123 | | | Hepato-Pancreatic Failure | | | | | |
| | | | | | | 3030 | | | | | |
| | | | | | | Chronic Alcoholism | | | | | |
| | | | | | | Large Pleural Effusion with Positive Tuberculosis Smear | | | | | |
| 19a. DATE OF OPERATION | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? | | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | 21b. TIME OF INJURY | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | | | | |
| | | | HOUR A.M. MONTH DAY YEAR | | | | | | | | |
| | | | P.M. 19 | | | | | | | | |
| 21d. INJURY OCCURRED | | | 21e. PLACE OF INJURY | | | 21f. LOCATION | | | | | |
| WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | | (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | | STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 1/29, 1981, to 1/29, 1981, that (I) (we) last saw the deceased alive on 1/28, 1981, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | 22b. SIGNATURE | | | DEGREE | | | 22c. DATE SIGNED | | |
| | | | S. A. Abrons | | | | | | 1-29-81 | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | | 22e. ADDRESS | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | | |
| S. ALBERT ABRONS MD. | | | PCHMC SALISBURY MD 21801 | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | | 23b. DATE | | | 23c. NAME OF CEMETERY OR CREMATORY | | | 23d. LOCATION | | |
| BURIAL | | | 1-31-81 | | | Mt. Zion Cemetery | | | CITY OR TOWN COUNTY STATE | | |
| | | | | | | | | | Delaware Rd | | |
| 24. FUNERAL DIRECTOR | | | 25a. DATE REC'D. BY REGISTRAR | | | 25b. REGISTRAR'S SIGNATURE | | | | | |
| NAME | | | ADDRESS | | | FEB 2 1981 | | | P. J. McBratney | | |
| Volley Memorial Chapel | | | Salis. Md | | | | | | | | |

MEDICAL CERTIFICATION

BP

DHMH-16 30M 2/80
(VRA 15, 4)



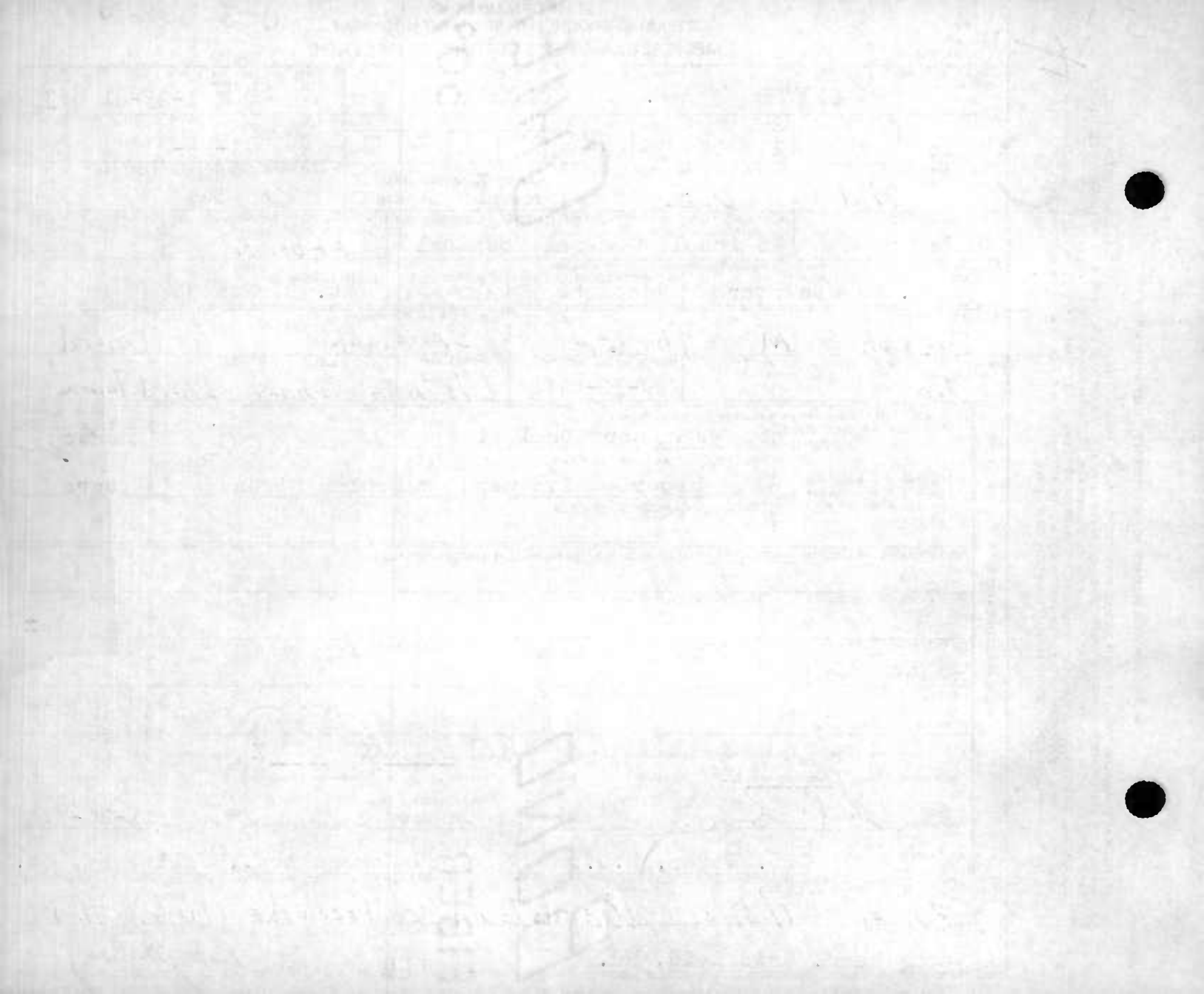
BP _____
DHMH - 17
TVR A15 ME (5)
15M7/76

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

REG. NO.

0 3 3 2 8

| FOR 1- STATE REGISTRAR | | | | | | | | | | DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|----------------------|--|---|--|--|--|---|--|---|--|---|--|--|---|--|-----------------------|--|--|----------|--|
| 1. DECEASED NAME (TYPE OR PRINT) OLIVER W. TURNER | | | | | 2a. DATE KNOWN OF DEATH ESTIMATED <input checked="" type="checkbox"/> MONTH DAY YEAR 1-25-81 8:35 AM | | | | | 2b. HOUR | | | | | | | | | | | |
| 3. SEX Male | | 4. RACE AA | | 5. DATE OF BIRTH MONTH DAY YEAR 11 15 35 | | 6. AGE (IN YEARS) LAST BIRTHDAY 45 YRS. | | IF UNDER 1 YR. MONTHS DAYS 0 0 | | IF UNDER 24 HRS. HOURS MIN 0 0 | | 2c. DATE PRONOUNCED DEAD MONTH DAY YEAR 1-25-81 19 | | | | | 2d. HOUR 11 | | | | |
| BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD | | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | | | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | | | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (GIVE STREET ADDRESS) Peninsula General Hospital | | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) LABORER | | | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | | |
| 13a. RESIDENCE (IF IN NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) STATE COUNTY Md. Worcester | | | | | 13b. CITY OR TOWN Pocomoke | | | | | 13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | 13d. STREET ADDRESS Rt. 2, Box 387 | | | | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Joseph M Turner | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST SAVANNAH Ward | | | | | | | | | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) (IF YES, GIVE WAR OR DATES) No | | | | | 16b. SOCIAL SECURITY NO. 220-32-0764 | | | | | 17. INFORMANT ADDRESS Victoria Turner - Ward Town | | | | | | | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I DEATH WAS CAUSED BY: 4100 IMMEDIATE CAUSE (a) Coronary Occlusion DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) Hypertensive Cardiovascular Disease DUE TO, OR AS A CONSEQUENCE OF (c) sudden years | | | | | | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a). | | | | | | | | | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | | | | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | | | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18 PART 1 OR PART 2) | | | | | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) | | | | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | | | | | |
| 22. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Earl L. Woyner | | | | | | | | | | TITLE (SPECIFY) Deputy | | | | | DATE SIGNED 1-26-81 | | | | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Earl L. Woyner, M.D. | | | | | | | | | | ADDRESS 409 Camden Ave., Salisbury, Md. | | | | | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | | 23b. DATE 1/31/81 | | | | | 23c. NAME OF CEMETERY OR CREMATORY Wards Town Cem. Pocomoke | | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Ward Md | | | | | | |
| 24. FUNERAL DIRECTOR NAME ADDRESS Anthony Ward, Crisfield, Md. | | | | | | | | | | 25a. DATE REC'D. BY REGISTRAR FEB 2 1981 | | | | | 25b. REGISTRAR'S SIGNATURE Barbara McCreedy | | | | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | |
|--|--|--|--|---|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | REG. NO. | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Stanford F. TWILLEY | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 23 1981 | | | 2b. HOUR 4:30 ^A _M | |
| 3. SEX MALE | | 4. RACE WHITE | | 5. DATE OF BIRTH MONTH DAY YEAR DEC. 4, 1899 | | 6. AGE (IN YEARS LAST BIRTHDAY) 81 YRS. | | IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN. | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) MD. | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) | | | | | | | | | |
| 13a. STATE MD. | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN SALISBURY | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS 105 VAN BUREN DR. | |
| 14. FATHER'S NAME FIRST MIDDLE LAST FRANCIS L. TWILLEY | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST CAROLINE S. MORRIS | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATES) | | 17. INFORMANT ADDRESS MRS. ANN H. TWILLEY SALISBURY, MD. | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) cerebrovascular accident 4360 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1979 | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a) | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | 21e. PLACE OF INJURY (AT HOME STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 4/23/79 to 1/23/81 , that (I) (we) last saw the deceased alive on 1/23/81 , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | |
| 22b. SIGNATURE Hwang | | DEGREE | | ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED 1/23/81 | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Inja J. Hwang, M.D. | | | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/26/81 | | 23c. NAME OF CEMETERY OR CREMATORY PARSONS CEMETERY | | 23d. LOCATION CITY OR TOWN COUNTY STATE SALISBURY, MD. | | | |
| 24. FUNERAL DIRECTOR NAME LEVIN R. WILSON | | | | 25a. DATE REC'D. BY REGISTRAR JAN 26 1981 | | 25b. REGISTRAR'S SIGNATURE Rickey McCreary | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use on the burial/transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. | |
|--|--|--|--|---|--------------------------|--|---|--|--------------------------------|--|--|
| 1. FOR STATE REGISTRAR | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| 1. DECEASED NAME (TYPE OR PRINT) | | | | | 2a. DATE OF DEATH | | | | | 2b. HOUR | |
| NICHOLAS A. VARRATO | | | | | JANUARY 27, 1981 | | | | | 12:59 AM | |
| 3. SEX | | 4. RACE | | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | IF UNDER 1 YEAR | | IF UNDER 24 HRS. | |
| MALE | | WHITE | | JULY 16, 1904 | | 76 YRS. | | MONTHS DAYS | | HOURS MIN. | |
| 7. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | | 7b. CITIZEN OF WHAT COUNTRY? | | 8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | |
| PENNSYLVANIA | | USA | | | | Wicomico MD. | | | | | |
| 10. CITY OR TOWN OF DEATH | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | | Peninsula General Hospital | | | | RET. MERCHANT | | DRUG STORE | | | |
| 13a. STATE | | | | | 13b. CITY OR TOWN | | 13c. INSIDE CITY LIMITS? | | 13d. STREET ADDRESS | | |
| DELAWARE | | | | | SUSSEX | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | OAK ORCHARD RD. (P.O. BOX 267) | | |
| 14. FATHER'S NAME | | | | | 15. MOTHER'S MAIDEN NAME | | | | | | |
| AMEDO VARRATO | | | | | EVA VARRATO | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT ADDRESS | | | | |
| | | | | | | | NICHOLAS A. VARRATO, JR. | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial infarct</u> <u>4100</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | |
| | | | | | | | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NO! WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21i. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>1-27</u> 19 <u>75</u> , to <u>1-27</u> 19 <u>81</u> , that (I) (we) last saw the deceased alive on <u>1-27</u> 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | |
| 22b. SIGNATURE <u>Wilber A. Ellis Jr. M.D.</u> | | | | DEGREE | | | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED <u>1-27-81</u> | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) <u>WILBER A. ELLIS JR. MD.</u> | | | | 22e. ADDRESS <u>KAY AVE. SALISBURY, MD 21801</u> | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL <u>BURIAL</u> | | | | 23b. DATE <u>1-30-81</u> | | 23c. NAME OF CEMETERY OR CREMATORY <u>MILLSBORO CEMETERY</u> | | 23d. LOCATION CITY OR TOWN COUNTY STATE <u>MILLSBORO, SUSSEX, DEL.</u> | | | |
| 24. FUNERAL DIRECTOR <u>Antonio Nelson</u> | | | | | | ADDRESS <u>MILLSBORO, DEL.</u> | | 25a. DATE REC'D. BY REGISTRAR <u>JAN 30 1981</u> | | 25b. REGISTRAR'S SIGNATURE <u>Lucy M. Brady</u> | |

BP

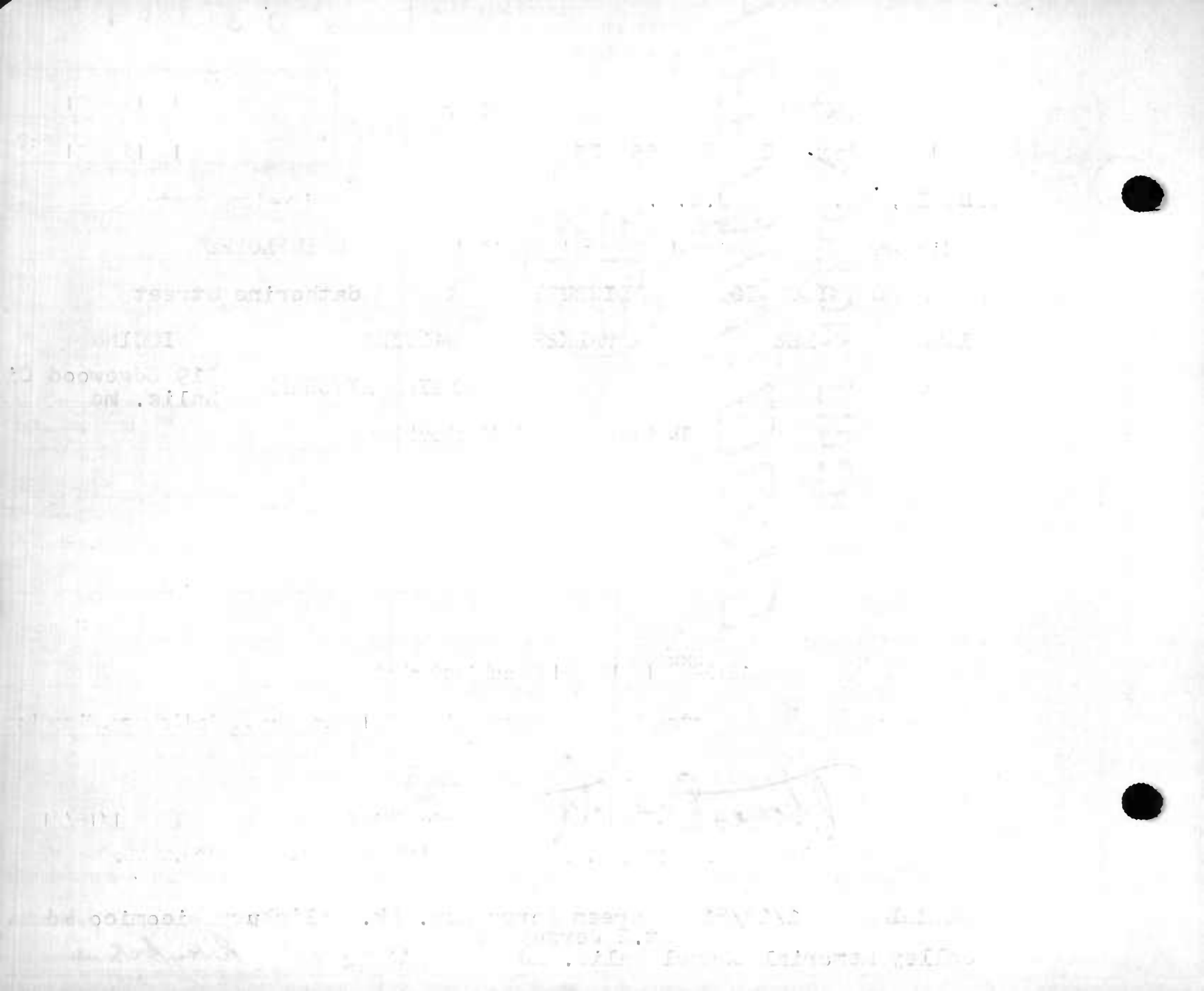


TO MEDICAL EXAMINER: THIS CERTIFICATE SHOULD BE EXECUTED WITHIN 24 HOURS AFTER DEATH. IF ANY DELAY IS NECESSARY, PLEASE EXECUTE THE CERTIFICATE, WRITING THE WORD "PENDING" IN PENCIL IN ITEM 1b. GIVE PAGES 1, 2, AND 3 TO THE FUNERAL DIRECTOR. PAGE 4 SHOULD BE FORWARDED TO THE CHIEF MEDICAL EXAMINER, ALONG WITH FORM PM. 3. RETAIN PAGE 5 FOR YOUR FILES. TO FUNERAL DIRECTOR: PAGE 3 SHOULD BE USED AS A BURIAL - TRANSIT PERMIT. PAGES 1 AND 2 SHOULD BE FILED, WITH 1272 HOURS AFTER DEATH, WITH THE STATE DEPARTMENT OF HEALTH AND MENTAL HYGIENE, DIVISION OF VITAL RECORDS, 201 W. PRESTON STREET, BALTIMORE, MARYLAND, 21201 PRIOR TO BURIAL, CREMATION, OR REMOVAL.

BP _____

DHMH - 17
(VR A15 ME (1))
15M 2/80

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | REG. NO. 03331 | |
|--|--|-------------------------|--|--|--|--|--|--|--|---|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | | |
| 1. DECEASED NAME (TYPE OR PRINT) Nathan Walker | | | | | | | | 2a. DATE KNOWN OF DEATH | | 2b. HOUR | |
| 3. SEX Male | | 4. RACE Black | | 5. DATE OF BIRTH MONTH DAY YEAR 2 8 55 | | 6. AGE (IN YEARS LAST BIRTHDAY) 25 YRS. | | 7c. DATE PRONOUNCED DEAD | | 7d. HOUR | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) VIDALIA, GA. | | | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico County, MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | | | 11. NAME OF HOSPITAL, NURSING HOME, OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) UNEMPLOYED | | 12b. KIND OF BUSINESS OR INDUSTRY | |
| 13a. STATE MARYLAND | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN SALISBURY | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | 13e. STREET ADDRESS Catherine Street | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST ISOM LEE WALKER | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST WALTINA WIGGINS | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO, OR UNKNOWN) NO | | | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT WALTINA MITCHELL | | | | ADDRESS 319 Edgewood Ci Salis, Md | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Shotgun wound left shoulder 9657 Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause last. (b) _____ (c) _____ DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF DUE TO, OR AS A CONSEQUENCE OF APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a). | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED? | | | | | | 20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. EXTERNAL CAUSE WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH | | | | 21b. TIME OF INJURY HOUR MONTH DAY YEAR 12:32 PM 1 15 1981 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 1b PART 1 OR PART 2) subject shot | | | | | |
| 21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/> | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, FARM, ETC.) street | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE West Main & Delaware Ave., Salisbury, Wicomico MD | | | | | |
| 22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE Thomas D. Smith | | | | TITLE (SPECIFY) M.D. Deputy Chief | | | | MEDICAL EXAMINER DATE SIGNED 1/16/81 | | | |
| EXAMINER'S NAME (TYPE OR PRINT) Thomas D. Smith, M.D. | | | | ADDRESS 111 Penn St. | | | | BALTO., MD. | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | | | 23b. DATE 1/18/81 | | 23c. NAME OF CEMETERY OR CREMATORY Green Acres Mem. Pk. | | | | 23d. LOCATION CITY OR TOWN COUNTY STATE Salisbury Wicomico Md | |
| 24. FUNERAL DIRECTOR NAME Jolley Memorial Chapel | | | | ADDRESS Rt. 2 Jersey Rd Salis. Md | | | | 25a. DATE REC'D. BY REGISTRAR JAN 22 1981 | | | |
| | | | | | | | | 25b. REGISTRAR'S SIGNATURE Rafael A. Brando | | | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 1 and 2 should be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

DHMH-16 30M 2/80
(VRA 15, 4)

| STATE OF MARYLAND DEPARTMENT OF HEALTH AND MENTAL HYGIENE CERTIFICATE OF DEATH | | | | | | | | | | 03332 | | | |
|--|--|--|--|---|--|--|--|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | | | | | | | | | REG. NO. | | | |
| 1. DECEASED NAME (TYPE OR PRINT) James LEWIS WEBB | | | | | | 2a. DATE OF DEATH MONTH DAY YEAR January 1, 1981 | | | | 2b. HOUR 8:00⁹ M | | | |
| 3. SEX Male | | 4. RACE Caucasian | | 5. DATE OF BIRTH MONTH DAY YEAR Dec. 21, 1898 | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | | IF UNDER 1 YEAR MONTHS DAYS | | IF UNDER 24 HRS. HOURS MIN. | | | |
| 7a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) Delaware | | 7b. CITIZEN OF WHAT COUNTRY? U.S. | | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | | | | | | | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Deer's Head Center | | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) farmer | | 12b. KIND OF BUSINESS OR INDUSTRY | | | | | |
| 13a. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) 13a. STATE Maryland | | | | | | 13b. COUNTY Talbot | | 13c. CITY OR TOWN Trappe | | 13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 14. FATHER'S NAME FIRST MIDDLE LAST Ernest C. Webb | | | | | | 15. MOTHER'S MAIDEN NAME FIRST MIDDLE LAST Ida Lewis | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) no | | | | | | 16b. SOCIAL SECURITY NO. 215-36-2287 | | 17. INFORMANT Ida S. Hickman ADDRESS see item 13 | | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: 4292 IMMEDIATE CAUSE (a) ASCVD with congestive heart failure, decompensated DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last | | | | | | | | | | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a): pacemaker for heart block, AK amputation @ leg | | | | | | | | | | | | | |
| 19a. DATE OF OPERATION | | | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | | | | |
| 22b. SIGNATURE Nancy W. Tustin, M.D. | | | | | | DEGREE ATTENDING PHYSICIAN <input type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input checked="" type="checkbox"/> | | 22c. DATE SIGNED | | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) Nancy W. Tustin, M.D. | | | | | | 22e. ADDRESS Deer's Head Center, Salisbury, Md. 21801 | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) Burial | | | | 23b. DATE 1-3-1981 | | 23c. NAME OF CEMETERY OR CREMATORY Spring Hill | | 23d. LOCATION CITY OR TOWN COUNTY STATE Easton, Talbot, Md. | | | | | |
| 24. FUNERAL DIRECTOR NAME Newnam Funeral Home | | | | | | ADDRESS Easton, Md. | | 25a. DATE REC'D. BY REGISTRAR JAN 5 1981 | | 25b. REGISTRAR'S SIGNATURE <i>Patricia McHenry</i> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Pages 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03333

| | | | | | | | | | | |
|---|--|---|--------|--|-------------------|---|-----------------------------------|--|------|--|
| 1. DECEASED NAME (TYPE OR PRINT) | | FIRST | MIDDLE | LAST | 2a. DATE OF DEATH | | MONTH | DAY | YEAR | 2b. HOUR |
| JAMES | | | | WINDER | JANUARY | | 4 | 1981 | 3:02 | M |
| 3. SEX | 4. RACE | 5. DATE OF BIRTH | | 6. AGE (IN YEARS LAST BIRTHDAY) | | 7. UNDER 1 YEAR | | 8. IF UNDER 24 HRS | | |
| Male | black | 3 8 04 | | Est 76 | | MONTHS | | DAYS | | HOURS MIN. |
| 9a. BIRTHPLACE (STATE OR FOREIGN COUNTRY) | 9b. CITIZEN OF WHAT COUNTRY? | 9c. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 9. BALTIMORE CITY OR COUNTY OF DEATH | | | | | | |
| Hebron, Md | U.S.A. | | | Wicomico MD | | | | | | |
| 10. CITY OR TOWN OF DEATH | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) | | | 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) | | | 12b. KIND OF BUSINESS OR INDUSTRY | | | |
| Salisbury | Peninsula General Hospital | | | farmer | | | farming | | | |
| 13a. STATE | | 13b. COUNTY | | 13c. CITY OR TOWN | | 13d. STREET ADDRESS | | | | |
| MARYLAND | | WICOMICO | | HEBRON | | LEVIN DASHIELL ROAD | | | | |
| 14. FATHER'S NAME | | 15. MOTHER'S MAIDEN NAME | | | | | | | | |
| UNKNOWN | | ESTELLA DASHIELL | | | | | | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) | | 16b. SOCIAL SECURITY NO. | | 17. INFORMANT | | ADDRESS | | | | |
| NO | | 212-12-3350 | | EDWARD WINDER | | SAME AS ABOVE | | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Carcinoma of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> | | | | | | | | | | APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 3 mos. 4 months |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | | | 20a. AUTOPSY? | | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? | | |
| | | | | | | YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | YES <input type="checkbox"/> NO <input type="checkbox"/> | | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART 1 OR PART 2) | | | | | | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | | | | | |
| 22a. I certify that (I) (this hospital) attended the deceased from <u>11/13</u> , 19 <u>76</u> , to <u>death</u> , 19 <u></u> , that (I) (we) last saw the deceased alive on <u>1/3</u> , 19 <u>81</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | | | | | | |
| 22b. SIGNATURE | | DEGREE | | | | 22c. DATE SIGNED | | | | |
| E. M. LARMORE MD | | ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | | | Jan 7, '81 | | | | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) | | 22e. ADDRESS | | | | | | | | |
| E. M. LARMORE | | DELMAR DEL | | | | 19940 | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) | | 23b. DATE | | 23c. NAME OF CEMETERY OR CREMATORY | | 23d. LOCATION CITY OR TOWN COUNTY STATE | | | | |
| BURIAL | | 1/8/81 | | JOHN WESLEY U.M. | | MARDELA WICOMICO MD | | | | |
| 24. FUNERAL DIRECTOR NAME | | ADDRESS | | 25a. DATE REC'D BY REGISTRAR | | 25b. REGISTRAR'S SIGNATURE | | | | |
| JOLLEY MEMORIAL CHAPEL | | SALIS. MD | | JAN 9 1981 | | [Signature] | | | | |

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STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

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|--|--|--|--|--|--|
| 1. FOR STATE REGISTRAR | | 2a. DATE OF DEATH MONTH DAY YEAR | | 2b. HOUR ⁴⁹ ₁₂ ^{PM} | |
| I. DECEASED NAME (TYPE OR PRINT) | | FIRST MIDDLE LAST | | ARCHIE WISE | |
| 3. SEX MALE | | 4. RACE BLACK | | 5. DATE OF BIRTH MONTH DAY YEAR 10 4 98 | |
| 7a. BIRTHPLACE (STATE OR FOREIGN) NASSAWADOX, VA | | 7b. CITIZEN OF WHAT COUNTRY? U.S.A. | | 6. AGE (IN YEARS LAST BIRTHDAY) 82 YRS. | |
| 10. CITY OR TOWN OF DEATH Salisbury | | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 12a. USUAL OCCUPATION (TYPE OF WORK FOR MOST OF WORKING LIFE) RETIRED | | 12b. KIND OF BUSINESS OR INDUSTRY FARMER | | | |
| 13a. STATE MARYLAND | | 13b. COUNTY WICOMICO | | 13c. CITY OR TOWN SALISBURY | |
| 14. FATHER'S NAME FIRST MIDDLE LAST LUTHER WISE | | 15. MOTHER'S MAIDEN NAME MIDDLE LAST LENA SMITH | | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. 227-20-2678 | | 17. INFORMANT ADDRESS FLOSSIE M. DOUGLAS SAME AS ABOVE | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hemorrhagic Diathesis DUE TO, OR AS A CONSEQUENCE OF (b) Generalized arteriosclerosis, vascular disease DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 18 yrs. 30 yrs. | | | | | |
| PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) | | | | | |
| 19a. DATE OF OPERATION | | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | |
| 21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK | | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | |
| 22a. I certify that (I) (this hospital) attended the deceased from _____, 19_____, to _____, 19_____, that (I) (we) last saw the deceased alive on _____, 19_____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death. | | | | | |
| 22b. SIGNATURE J. Francis Warren | | DEGREE M.D. ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | | 22c. DATE SIGNED 2-8-81 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) J. Francis Warren | | 22e. ADDRESS Berlin Nursing Home | | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | | 23b. DATE 1/31/81 | | 23c. NAME OF CEMETERY OR CREMATORY Timmons Cemetery | |
| 24. FUNERAL DIRECTOR NAME JOLLEY MEMORIAL CHAPEL | | ADDRESS JERSEY ROAD SALIS. MD. | | 23d. LOCATION CITY OR TOWN COUNTY STATE SNOW HILL WORCESTER MD | |
| | | 25a. DATE REC'D. BY REGISTRAR FEB 9 1981 | | 25b. REGISTRAR'S SIGNATURE L. J. K. K. K. | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. It may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked or item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, it should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed within 72 hours after death with the State Dept. of Health and Mental Hygiene prior to burial, cremation, or removal.

IMPORTANT: If item 21 is marked on item 18 shows any injury, or other traumatic event, the medical examiner must be notified at once.

Item 6-G 552 2/27/81 GB

STATE OF MARYLAND
DEPARTMENT OF HEALTH AND MENTAL HYGIENE
CERTIFICATE OF DEATH

REG. NO.

03335

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|--|--|---|--|--|
| 1. DECEASED NAME (TYPE OR PRINT) ROSA WRIGHT | | 2a. DATE OF DEATH MONTH JANUARY DAY 3 YEAR 1981 | | 2b. HOUR 10²⁰ M |
| 3. SEX FEMALE | 4. RACE BLACK | 5. DATE OF BIRTH JUNE 6, 1894 | 6. AGE (IN YEARS LAST BIRTHDAY) 87 YRS. 86 YRS. | 7. IF UNDER 1 YEAR MONTHS DAYS HOURS MIN. |
| 7a. BIRTHPLACE (STATE OR FOREIGN) MARYLAND | 7b. CITIZEN OF WHAT COUNTRY? UNITED STATES | 8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 9. BALTIMORE CITY OR COUNTY OF DEATH Wicomico MD. | |
| 10. CITY OR TOWN OF DEATH Salisbury | 11. NAME OF HOSPITAL, NURSING HOME OR OTHER INSTITUTION (IF NOT IN SUCH FACILITY, GIVE STREET ADDRESS) Peninsula General Hospital | | 12a. USUAL OCCUPATION (IF NOT EMPLOYED, GIVE WORKING LIFE) HOUSEWIFE | 12b. KIND OF BUSINESS OR INDUSTRY NONE |
| 13. USUAL RESIDENCE (IF NURSING HOME OR OTHER INSTITUTION, GIVE RESIDENCE BEFORE ADMISSION) MARYLAND CAROLINE HILLSBORO | | 13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | 13e. STREET ADDRESS GENERAL DELIVERY | |
| 14. FATHER'S NAME FIRST WILLIAM MIDDLE (NMN) LAST MILLER | | 15. MOTHER'S MAIDEN NAME FIRST SARAH MIDDLE (NMN) LAST SMITH | | |
| 16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (YES, NO OR UNKNOWN) NO | | 16b. SOCIAL SECURITY NO. (IF YES, GIVE WAR OR DATE) NO | | 17. INFORMANT ADDRESS RECORDS OF PENINSULA GENL HOSPITAL |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Severe Cerebral Arteriosclerosis 4370 DUE TO, OR AS A CONSEQUENCE OF: (b) _____ DUE TO, OR AS A CONSEQUENCE OF: (c) _____ Conditions, if any, which give rise to immediate cause (a), stating the underlying cause last. | | | | |
| PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a): Pulmonary Tuberculosis - Chronic Brain Syndrome | | | | |
| 19a. DATE OF OPERATION | 19b. CONDITION FOR WHICH OPERATION WAS PERFORMED | 20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | 20b. IF YES, WERE FINDINGS USED IN CERTIFYING CAUSES OF DEATH? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | 21b. TIME OF INJURY HOUR A.M. MONTH DAY YEAR P.M. 19 | 21c. HOW INJURY OCCURRED (ENTER NATURE OF INJURY IN ITEM 18, PART I OR PART 2) | | |
| 21d. INJURY OCCURRED: WHILE <input type="checkbox"/> AT WORK NOT WHILE <input type="checkbox"/> AT WORK | 21e. PLACE OF INJURY (AT HOME, STREET, FACTORY, OFFICE, FARM, ETC.) | 21f. LOCATION STREET CITY OR TOWN COUNTY STATE | | |
| 22a. I certify that (I) (this hospital) attended the deceased from 11/19/80 to 1/3/81 that (I) (we) last saw the deceased alive on 1/2/81 and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death. | | | | |
| 22b. SIGNATURE Oswald Burton | | DEGREE ATTENDING PHYSICIAN <input checked="" type="checkbox"/> MEDICAL DIRECTOR <input type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/> | 22c. DATE SIGNED JAN 4, 1981 | |
| 22d. PHYSICIAN'S NAME (TYPE OR PRINT) OSWALD BURTON, M.D., | | 22e. ADDRESS SALISBURY, MARYLAND (21801) | | |
| 23a. BURIAL, CREMATION, REMOVAL (SPECIFY) BURIAL | 23b. DATE JAN 8, 1981 | 23c. NAME OF CEMETERY OR CREMATORY COKER CEMETERY | 23d. LOCATION CITY OR TOWN COUNTY STATE GREENSBORO CAROLINE, MD | |
| 24. FUNERAL DIRECTOR NAME CHARLES W. HILL, DENTON, MD | | 25a. DATE REC'D. BY REGISTRAR JAN 13 1981 | 25b. REGISTRAR'S SIGNATURE John H. Harty | |

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